Supreme Court, U.S.
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In The

Supreme Court of the United States

UNITED STATES OF AMERICA *ex rel.*
KIRK S. CORSELLO,

Petitioner,

v.

LINCARE, INC., LINCARE HOLDINGS, INC.,
LINCARE HEALTHCARE GROUP, INC.,
AMERICAN HOMEPATIENT, INC., ROTECH, INC.,
ROTECH MEDICAL CORPORATION, and
ALAN VARRAUX, M.D.,

Respondents.

On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Eleventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the court of appeals' restrictive interpretation of Fed. R. Civ. P. 9(b) imposes an excessive burden on *qui tam* relators that is contrary to this Court's precedents, is inconsistent with the language and purposes of the rule, and undermines Congress's stated intent to encourage whistleblowers with knowledge of wrongdoing to come forward.

2. Whether failure to comply with Fed. R. Civ. P. 9(b)'s requirement that, "[i]n all averments of fraud . . . , the circumstances constituting fraud . . . shall be stated with particularity," is in all cases fatal to a complaint filed under the False Claims Act, when the False Claims Act expressly provides that intent to defraud need not be proven and imposes liability in circumstances that do not constitute fraud.

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PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

Petitioner Kirk S. Corsello respectfully petitions for a Writ of Certiorari to review the judgment of the United States Court of Appeals for the Eleventh Circuit in this case.

OPINIONS BELOW

The Opinion of the Eleventh Circuit Court of Appeals is reported at *Corsello v. Lincare, Inc.*, 428 F.3d 1008 (11th Cir. 2005). App. at 1.[1] The Order denying rehearing is unreported. App. at 49.

JURISDICTION

This Court has jurisdiction to consider this case by way of a Writ of Certiorari pursuant to 28 U.S.C. § 1254(1). The Opinion of the Eleventh Circuit Court of Appeals was issued on October 20, 2005. The petition for rehearing was denied on January 6, 2006.

STATUTORY PROVISIONS INVOLVED

Federal Rule of Civil Procedure 9(b) provides in pertinent part: "Fraud, Mistake, Condition of the Mind. In all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity. Malice, intent, knowledge, and other condition of mind of a person may be averred generally."

Pertinent provisions of the False Claims Act, 31 U.S.C. § 3729-3730, are set forth in the attached Appendix. App. at 51-61.

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[1] "App." refers to the attached Appendix to the Petition for a Writ of Certiorari.

STATEMENT OF THE CASE

Kirk S. Corsello ("Relator") filed his original *qui tam* complaint under seal on January 22, 1998, alleging that various defendants were liable under the False Claims Act, 31 U.S.C. § 3729 *et seq.*, for presenting false claims for payment to the United States. On January 13, 2000, after the government declined to intervene, Relator filed a Second Amended Complaint ("SAC") against defendants Lincare, Inc. and Lincare Holdings, Inc. (collectively, "Lincare"), Rotech Medical Corporation ("Rotech"), American HomePatient, Inc. ("AHP"), and Dr. Alan Varraux. Lincare, Rotech, and AHP were nationwide providers of durable medical equipment and home health services. Relator was previously employed by Lincare as a center manager in Orlando, Florida, and by Rotech as a regional salesman.

In the SAC, Relator alleged that the defendants submitted false claims for payment to Medicare and Medicaid in a variety of ways. Most importantly, Relator alleged that the defendants routinely submitted claims that were false because they were based on required Certificates of Medical Necessity ("CMNs") that had been forged, altered, or otherwise improperly completed. SAC, ¶¶ 52-104. The SAC provided dozens of examples of individual claims submitted as a result of this practice, providing the initials of the patient, the date of the CMN, and in many cases the name of the employee falsifying the document. SAC, ¶¶ 59, 76, 81, 92. Relator also alleged, among other things, that a large number of claims were false because they were based on patient referrals that were induced by unlawful kickbacks to the referring physician. SAC, ¶¶ 23-48.

On March 9, 2001, the district court entered an order dismissing the SAC with prejudice for failure to comply with the particularity requirements of Fed. R. Civ. P. 9(b) ("Rule 9(b)"). App. at 30. Relator filed a notice of appeal on April 6, 2001. On December 20, 2001, however, the Eleventh Circuit Court of Appeals dismissed the appeal as being premature, holding that the claims against defendant

Rotech, which was in bankruptcy, were not adjudicated by the district court's order and thus remained pending.

Upon remand, on September 2, 2002, Rotech, having emerged from bankruptcy, filed its own motion to dismiss the SAC. On October 18, 2002, Relator filed his response to Rotech's motion, and also filed a proposed Third Amended Complaint ("TAC"), which added no new substantive allegations, but merely undertook to provide the types of "indicia of reliability" which the Eleventh Circuit, in its recent decision in *U.S. ex rel. Clausen v. Laboratory Corp. of America*, 290 F.3d 1301 (11th Cir. 2002), had held for the first time were necessary to support an allegation that claims had been submitted. In particular, the TAC added allegations demonstrating Relator's familiarity with defendant's billing practices. TAC, ¶¶ 66, 184, 195-205.

On June 2, 2003, the district court granted Rotech's motion to dismiss Relator's *qui tam* claims in the SAC pursuant to Rule 9(b). The court denied Rotech's motion to dismiss the SAC's separate retaliation claim. App. at 25. The court also modified its March 9, 2001 dismissal order to reinstate Relator's retaliation claim against Lincare. App. at 27. The court denied Relator leave to file the TAC, in large part because it felt that the TAC would not cure the defects in the SAC. App. at 28.

Following dismissal of the retaliation claims, Relator filed his notice of appeal on April 1, 2005. On October 20, 2005, the Eleventh Circuit entered an opinion affirming the district court's ruling, and holding that Relator's complaints did not satisfy Rule 9(b). App. at 1.

REASONS FOR GRANTING THE PETITION

This Court should grant certiorari because the proper application of Fed. R. Civ. P. 9(b) is an issue of overwhelming importance with respect to the False Claims Act, the country's primary tool for combating fraud on the American taxpayers.

This Court has never directly tackled the issue of how properly to apply Rule 9(b)'s requirement that the

"circumstances constituting fraud" be "stated with particularity." In those few cases where this Court has mentioned Rule 9(b), it has done so parenthetically, in the context of addressing other issues. However, these cases have suggested that Rule 9(b) is to be applied liberally, and is not to be extended beyond its clear terms.

The lack of any clear guidance by this Court has led to divergent approaches in the lower courts regarding the application of Rule 9(b) to False Claims Act cases. In the Eleventh Circuit at least, Rule 9(b) has been transformed from a rule of particularity into a rule of substance, with plaintiffs being required not merely to state their allegations with sufficient "particularity," but also to demonstrate that they are sufficiently "reliable." This requirement is directly contrary to this Court's admonition that, on a motion to dismiss, the allegations of the complaint must be accepted as true and construed in the light most favorable to the plaintiff.

Moreover, in applying its "reliability" test to cases involving fraudulent submission of claims to Medicare or Medicaid – by far the largest category of FCA claims – the Eleventh Circuit has effectively held that only those persons working in a defendant's billing department can properly allege that claims for payment have been submitted to the government as a result of the defendant's fraudulent schemes. This ruling will have a devastating impact on the effectiveness of the False Claims Act as a tool for combating fraud, since billing employees are unlikely to be in a position to spot a defendant's fraudulent practices. In effect, the Eleventh Circuit has limited the universe of potential whistleblowers to those persons who are unlikely to have any knowledge of fraud. In order to preserve the effectiveness of the FCA as a tool for fighting fraud, the Court should grant certiorari to review the decision below.

I. The importance of the False Claims Act.

The False Claims Act is the government's primary tool for combating fraud against the federal government. *See*

Vermont Agency of Natural Resources v. United States ex rel. Stevens, 529 U.S. 765, 792, 120 S.Ct. 1858, 146 L.Ed.2d 836 (2000) (Stevens, J., dissenting); *McNutt ex rel. United States v. Haleyville Med. Supplies, Inc.*, 423 F.3d 1256, 1259 (11th Cir. 2005); *Avco Corp. v. United States Dep't of Justice*, 884 F.2d 621, 622 (D.C. Cir. 1989). The Act allows a private citizen, commonly known as a "relator," to bring an action on behalf of the relator and the United States against persons who present false or fraudulent claims to the government. If the government intervenes in the action, the relator is entitled to receive 15-25% of the proceeds. If the government declines to intervene, the relator has the exclusive right to prosecute the action himself, and is entitled to receive 25-30% of the proceeds. *Vermont Agency, supra*, 529 U.S. at 769-770; 31 U.S.C. § 3730(c), (d).

The FCA was originally enacted in 1863, with the goal of "stopping the massive frauds perpetrated by large contractors during the Civil War." *United States v. Bornstein*, 423 U.S. 303, 309, 46 L.Ed.2d 514, 96 S.Ct. 523 (1976); *see also Vermont Agency*, 529 U.S. at 781. However, the FCA was little used over the following decades, and its effectiveness was further reduced by amendments in 1943 and subsequent judicial decisions, which greatly restricted individuals' ability to bring actions under the statute. *See United States ex rel. Stinson, Lyons, Gerlin & Bustamante, P.A. v. Prudential Ins. Co.*, 944 F.2d 1149, 1153 (3d Cir. 1991) and *Campbell v. Redding Med. Ctr.*, 421 F.3d 817, 823 (9th Cir. 2005) (discussing 1943 amendments and subsequent judicial interpretations).

In the face of mounting evidence that "fraud in Government programs and procurement [was] on a steady rise," *Vermont Agency*, 529 U.S. at 793 n.4 (Stevens, J., dissenting), Congress substantially overhauled the statute in 1986. As the Eleventh Circuit has noted, "fraud against government [was] so rampant and difficult to identify [that the] government needed all [the] help it could get from private citizens." *Cooper v. Blue Cross and Blue Shield of Florida, Inc.*, 19 F.3d 562, 566 (11th Cir. 1994),

citing United States ex rel. LaValley v. First Nat'l Bank, 707 F.Supp. 1351, 1355 (D. Mass. 1988).

The primary purpose of the 1986 amendments was to induce persons with knowledge of fraud to come forward and file *qui tam* actions. S. Rep. No. 345, 99th Cong. 2d Sess. 6, *reprinted in* 1986 U.S. Code Cong. & Admin. News 5271, 5288-5289 ("The Committee's overall intent in amending the *qui tam* section of the False Claims Act is to encourage more private enforcement suits."). As the Third Circuit noted:

> One theme recurring through the legislative history in 1985 is the intent to encourage persons with first-hand knowledge of fraudulent misconduct to report fraud. Congress sought to stop the "conspiracy of silence" among employees of corporations engaging in fraud. *See* S. Rep. No. 345, 99th Cong. 2d Sess. 6, *reprinted in* 1986 U.S. Code Cong. & Admin. News 5271.

Stinson, 944 F.2d at 1154.

The 1986 amendments allowed cases to be brought even when the government had knowledge of the relevant facts, provided relators with a guaranteed share of any recovery, expanded the relator's participation in the litigation even where the government elects to intervene, and increased the damages recoverable under the Act. *See* 31 U.S.C. §§ 3729(a)-(b), 3730(d). The amendments also expressly provided that specific intent to defraud need not be shown, clarifying that a defendant may be liable if it acts with deliberate ignorance or reckless disregard of the truth or falsity of information. 31 U.S.C. § 3729(b).

This Court has recognized the fundamental changes wrought by the 1986 amendments:

> The basic purpose of the 1986 amendments was to make the FCA a "more useful tool against fraud in modern times." S. Rep., at 2. Because Congress was concerned about pervasive fraud in "all Government programs," ibid., it allowed private parties to sue even based on information

> already in the Government's possession, *see Hughes Aircraft Co. v. United States ex rel. Schumer*, 520 U.S. 939, 946, 138 L. Ed. 2d 135, 117 S. Ct. 1871 (1997); increased the Government's measure of recovery; and enhanced the incentives for relators to bring suit.

Cook County v. United States ex rel. Chandler, 538 U.S. 119, 133, 123 S.Ct. 1239, 155 L.Ed.2d 247 (2003). As the Seventh Circuit has noted, "[e]very change made in 1986 made it more likely for FCA claims to be filed and to succeed." *United States ex rel. Chandler v. Cook County, Illinois*, 277 F.3d 969, 975 (7th Cir. 2002), *aff'd*, 538 U.S. 119 (2003).

Since the passage of the 1986 amendments, as the statute has become more widely-known, the FCA has become an increasingly important tool in combating fraud on the taxpayers. Since 1987, the government has recovered more than $15 billion pursuant to the FCA, of which nearly two-thirds, or $9.6 billion, has resulted from *qui tam* actions brought by private relators. Approximately $400 million of this amount represents recoveries in cases where the United States declined to intervene, and the case was prosecuted by the relator. *See* http://www.taf.org/fcastatistics2006.pdf.

Underscoring the central importance of the FCA, this Court has four times in the past nine years granted certiorari to resolve issues surrounding the statute. *See Graham County Soil & Water Conservation Dist. v. United States ex rel. Wilson*, 125 S.Ct. 2444, 162 L.Ed.2d 390 (2005) (addressing statute of limitations for FCA retaliation claims); *Cook County*, *supra* (holding that counties are subject to liability under FCA); *Vermont Agency, supra* (holding that relator has standing to bring action based on partial assignment from United States; also holding that States and State agencies are not "persons" subject to the FCA); *Hughes Aircraft Co. v. United States ex rel. Schumer*, 520 U.S. 939, 117 S.Ct. 1871, 138 L.Ed.2d 135 (1997) (addressing retroactivity of 1986 amendments). However, the Court has never granted certiorari to consider the extremely important

question of the proper application of Rule 9(b) to FCA cases.

II. This Court has never directly addressed the proper application of Rule 9(b).

Since the adoption of Rule 9(b) in 1938, this Court has never granted certiorari for the purpose of determining the proper application of the rule. Indeed, the Court has mentioned Rule 9(b) in only a handful of cases over the past 68 years, and only in the context of addressing other issues. Those decisions have made it clear, however, that the rule is to be applied liberally, and is not to be extended beyond its express terms.

Perhaps this Court's most extensive commentary on Rule 9(b) came in *Rotella v. Wood*, 528 U.S. 549, 120 S.Ct. 1075, 145 L.Ed.2d 1047 (2000), where the Court granted certiorari to determine when the statute of limitations begins for RICO claims. In rejecting the argument that the limitations period begins upon discovery of the pattern of racketeering activity, the Court briefly touched on Rule 9(b):

> Finally, Rotella returns to his point that RICO patterns will involve fraud in many cases, when he argues that unless a pattern discovery rule is recognized a RICO plaintiff will sometimes be barred from suit by Federal Rule of Civil Procedure 9(b), which provides that fraud must be pleaded with particularity. While we will assume that Rule 9(b) will exact some cost, we are wary of allowing speculation about that cost to control the resolution of the issue here. Rotella has presented no case in which Rule 9(b) has effectively barred a claim like his, and *he ignores the flexibility provided by Rule 11(b)(3), allowing pleadings based on evidence reasonably anticipated after further investigation or discovery. See, e.g., Corley v. Rosewood Care Center, Inc. of Peoria*, 142 F.3d 1041, 1050-1051 (CA7 1998) (relaxing particularity requirements of Rule 9(b) where

> RICO plaintiff lacks access to all facts necessary to detail claim).

Rotella, 528 U.S. at 560 (emphasis added).

Thus, the one aspect of Rule 9(b) that the Court chose to emphasize was its "flexibility," noting that the rule would be relaxed where the plaintiff lacked access to information. Significantly, the case the Court cited on this point, *Corley v. Rosewood Care Center, Inc. of Peoria*, relied on concerns that are directly applicable to False Claims Act cases. In *Corley*, the Seventh Circuit stated that:

> We have noted on a number of occasions that the particularity requirement of Rule 9(b) must be relaxed where the plaintiff lacks access to all facts necessary to detail his claim, and *that is most likely to be the case where, as here, the plaintiff alleges a fraud against one or more third parties.*

Corley, 142 F.3d at 1051 (emphasis added). The exact same situation exists in False Claims Act cases, since the relator is bringing an action for fraud committed, not against himself, but against a third party – the United States government. Thus, to the extent that *Rotella* discusses Rule 9(b), it strongly suggests that, where the fraud is directed against third parties other than the plaintiff, the rule is to be relaxed to allow the plaintiff to obtain detailed information in discovery.

In two other cases, this Court refused to extend Rule 9(b) to actions other than for fraud. In *Leatherman v. Tarrant County Narcotics Intelligence and Coordination Unit*, 507 U.S. 163, 113 S.Ct. 1160, 122 L.Ed.2d 517 (1993), the Court held that civil rights cases alleging municipal liability need not satisfy a "heightened pleading standard" beyond that required by Rule 8(a). In so holding, the Court stated that:

> Rule 9(b) does impose a particularity requirement in two specific instances. It provides that "in all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity." Thus, the Federal

> Rules do address in Rule 9(b) the question of the need for greater particularity in pleading certain actions, but do not include among the enumerated actions any reference to complaints alleging municipal liability under § 1983. *Expressio unius est exclusio alterius.*

Id., 507 U.S. at 168. Subsequently, in *Swierkiewicz v. Sorema*, 534 U.S. 506, 122 S.Ct. 992, 152 L.Ed.2d 1 (2002), this Court relied on *Leatherman* to hold that a complaint alleging employment discrimination "must contain only 'a short and plain statement of the claim showing that the pleader is entitled to relief.' Fed. R. Civ. Proc. 8(a)(2)." *Swierkiewicz*, 534 U.S. at 508. In so holding, the Court rejected the notion that Rule 9(b) applied to claims of employment discrimination. *Id.* at 513.

Neither *Leatherman* nor *Swierkiewicz* addresses the proper application of Rule 9(b) in cases where the rule does apply. However, both cases make it clear that Rule 9(b) is not to be stretched beyond its express terms.

In one other case, nearly 60 years ago, the Court briefly mentioned Rule 9(b), but without any discussion. *See Klapprott v. United States*, 335 U.S. 601, 615, 69 S.Ct. 384, 93 L.Ed. 266 (1949) (discussing district court's power to enter default judgment depriving a naturalized citizen of his citizenship). Thus, in the 68 years since Rule 9(b) was adopted, this Court has yet to issue an opinion providing significant guidance as to how the rule is to be applied.

III. The lack of guidance from this Court has led to confusion in the lower courts as to the proper application of Rule 9(b) in FCA cases.

It is not an understatement to say that Rule 9(b) is perhaps the single biggest roadblock to *qui tam* relators today. The leading treatise on the False Claims Act by a prominent FCA defense attorney contains 23 pages devoted to "The Application of Rule 9(b) to False Claims Act Complaints." John T. Boese, Civil False Claims and *Qui Tam* Actions, Vol. 2, § 5.04, p. 5-43 – 5-66 (3d ed. 2006). A

Lexis search of the terms "Rule 9(b)" and "False Claims Act" yields more than 330 cases.

Every circuit to have considered the issue has uncritically accepted that a complaint brought under the False Claims Act must in all circumstances comply with Rule 9(b)'s particularity requirement. As discussed below, these holdings are mistaken, since a relator may prove an FCA violation without proving fraud. Putting aside the threshold question of whether Rule 9(b) applies, however, the lack of guidance from this Court has led to lower courts applying a hodge-podge of approaches to Rule 9(b) in False Claims Act cases.

As the Department of Justice has noted, the single largest category of FCA cases involves claims of healthcare fraud, in particular Medicare and Medicaid fraud. *See* http://www.usdoj.gov/opa/pr/2005/November/05_civ_595.html ("As in the last several years, health care accounted for the lion's share of fraud settlements and judgments" in FY 2005). These cases allege that claims are false or fraudulent for a number of reasons. Many cases allege that individual claims for Medicare reimbursement are false because they are based on patient referrals that have been induced by improper kickbacks. *See, e.g., United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 20 F.Supp.2d 1017 (D. Tex. 1998). Other cases allege that Medicaid claims for pharmaceuticals are false because the prescriptions have been induced by off-label marketing of a medication. *See United States ex rel. Franklin v. Parke-Davis*, 147 F.Supp.2d 39 (D. Mass. 2001). Still others, such as this case, allege that claims are false because the underlying physician order or authorization has been altered or is in some way improper. *See Corsello v. Lincare, Inc.*, 428 F.3d 1008 (11th Cir. 2005).

The common thread for each of these types of cases is that they involve the submission of a large number of claims – thousands or tens of thousands – over an extended period of time. In considering the proper application of Rule 9(b) to these types of cases, lower courts have put forth widely divergent approaches.

A. Some cases hold that allegations regarding the "fraudulent scheme" are sufficient to satisfy Rule 9(b).

Many courts, when faced with Rule 9(b) challenges to such complaints, have held that it is not necessary for the relator to identify specific claims for payment submitted as a result of the defendant's "fraudulent scheme," reasoning that such identification is not necessary to put the defendants on notice of their alleged misconduct, and that the individual billing records are in the possession of the defendant. In *Franklin, supra*, 147 F.Supp.2d 39, for example, the relator alleged that a drug manufacturer violated the FCA by promoting one of its drugs for "off-label" uses, or uses other than those approved by the Food and Drug Administration. The defendant argued that "the pleading of the basic scheme of fraud or the identification of certain instances of fraudulent conduct does not satisfy Rule 9(b)." *Id.* at 49. The court rejected this argument, noting that:

> [t]his view of Relator's pleading obligation may fit a scenario where the alleged fraud is confined to a small number of transactions about which Relator had knowledge. However, where the alleged scheme of fraud is complex and far-reaching, pleading every instance of fraud would be extremely ungainly, if not impossible. . . . Although the Relator here does not identify specific prescriptions for Medicaid patients for off-label uses made by doctors in reliance on the fraudulent representations, [the Relator] . . . does not reasonably have pre-discovery access to that patient-specific information.

Id.

Similarly, in *United States ex rel. Pogue v. American Healthcorp, Inc.*, 977 F.Supp. 1329, 1333 (M.D. Tenn. 1997), the court rejected a Rule 9(b) challenge to a complaint which alleged that contractual relationships between doctors and hospitals constituted a kickback scheme

that resulted in the filing of Medicare claims. The court stated that:

> [a]lthough no specific dates or West Paces employees are identified, the complaint alleges that the hospital participated in a systematic, fraudulent scheme, spanning the course of twelve years; thus, reference to a time frame and to "West Paces" generally is sufficient. . . . [R]equiring Plaintiff to refer to the specific instances underlying each Medicare and Medicaid claim submission that he claims was fraudulent in his [complaint] would undermine Rule 8's admonishment to keep pleadings simplistic.

Id. (internal quotation marks omitted). Other cases illustrative of this approach include *United States ex rel. Downy v. Corning, Inc.*, 118 F.Supp.2d 1160, 1173 (D.N.M. 2000) (noting that, in complaint alleging submission of false claims for unnecessary medical tests, "some form of limited discovery would probably be necessary to allow Relator to provide such specific examples"); and *Thompson, supra*, 20 F.Supp.2d at 1049 (S.D. Tex. 1998) (noting that "The basic framework, procedures, the nature of the fraudulent scheme, and the financial arrangements and inducements among the parties and physicians that give rise to Relator's belief that fraud has occurred have been alleged with specificity").

B. Some cases hold that identification of specific claims submitted as a result of the fraudulent schemes is required.

Another line of cases has held that it is not sufficient to provide detail regarding the defendant's fraudulent scheme, but that a relator must also provide detailed information regarding individual claims submitted as a result of such schemes. This line of cases is illustrated by *United States ex rel. Karvelas v. Melrose-Wakefield Hosp.*, 360 F.3d 220, 232 (1st Cir. 2004), where the court held that:

> Underlying schemes and other wrongful activities that result in the submission of fraudulent claims are included in the "circumstances constituting fraud or mistake" that must be pled with particularity pursuant to Rule 9(b). However, such pleadings invariably are inadequate unless they are linked to allegations, stated with particularity, of the actual false claims submitted to the government that constitute the essential element of an FCA qui tam action.

Other cases illustrative of this approach include *United States ex rel. Russell v. Epic Healthcare Mgmt. Group*, 193 F.3d 304, 308 (5th Cir. 1999) ("The conduct to which liability attaches in a False Claims Act suit consists in part of false statements or claims for payment presented to the government. . . . Because such statements or claims are among the circumstances constituting fraud in a False Claims Act suit, these must be pled with particularity under Rule 9(b)."); *United States ex rel. Walsh v. Eastman Kodak Co.*, 98 F.Supp.2d 141, 147 (D. Mass. 2000) ("Without citing a single false claim arising from an allegedly false invoice, Relator has not met even a bare-bones Rule 9(b) test."); *United States ex rel. Butler v. Magellan Health Serv., Inc.*, 101 F.Supp.2d 1365, 1369 (M.D. Fla. 2000) ("Plaintiff does plead a fraudulent scheme of conduct which may well be prohibited by law. However, Plaintiff pleads no specific occurrences of a false claim. . . . The absence of specific allegations of fraudulent false claims is determinative.").

C. Some cases disregard express allegations unless the complaint contains sufficient "indicia of reliability."

A third line of cases – which includes the present case – has held that it is not sufficient to allege the "fraudulent scheme" in detail, nor is it sufficient to identify particular claims that are alleged to have been submitted as a result of such schemes. Rather, this line of cases holds that the relator's express allegations of claim submission may be

disregarded if they are not supported by sufficient "indicia of reliability."

This "indicia of reliability" test originated with the Eleventh Circuit's decision in *United States ex rel. Clausen v. Laboratory Corp. of America*, 290 F.3d 1301 (11th Cir. 2002). In that case, the relator alleged that the defendant routinely submitted false claims to the Medicare program for laboratory tests that were unnecessary, duplicative, or otherwise improper. In addition to alleging the details of the fraudulent scheme, the complaint also identified a large number of specific tests that were performed, providing the patient initials, the date of the test, and the type of test; described why the tests were improper; and expressly alleged that a claim for payment was submitted on the date of the test or within a few days thereafter. *Id.* at 1304-1306 and n.7.

Notwithstanding this level of detail, the Eleventh Circuit disregarded the relator's express allegations regarding the submission of claims. The Court held that:

> Rule 9(b)'s directive that "the circumstances constituting fraud or mistake shall be stated with particularity" does not permit a False Claims Act plaintiff merely to describe a private scheme in detail but then to allege simply and without any stated reason for his belief that claims requesting illegal payments must have been submitted, were likely submitted or should have been submitted to the Government. As in *Cooper*, and as with every other facet of a necessary False Claims Act allegation, if Rule 9(b) is to be adhered to, *some indicia of reliability must be given in the complaint to support the allegation of an actual false claim for payment being made to the Government.*

Id. at 1311 (emphasis added).

The court noted that the *Clausen* relator was not an employee of the defendant, and assumed that, being a "corporate outsider," the relator was "not . . . privy to [the defendant's] policy manuals, files and computer systems." *Id.* at 1302-03, 1314. Thus, the Court was skeptical as to

whether the relator was telling the truth when he alleged that claims were in fact submitted for payment to the government. *See id.* at 1313 ("we cannot be left wondering whether a plaintiff has offered mere conjecture or a specifically pleaded allegation on an essential element of the lawsuit"); 1313 n.23 ("we cannot . . . assume LabCorp actually billed the Government in whole or in part for all tests it 'took the trouble to order' "); 1312 n.21 ("We cannot make assumptions about a False Claims Act defendant's submission of actual claims to the Government"). In short, although the complaint expressly alleged that specific claims for payment were submitted, the Court disregarded such allegations because it did not know whether the relator was telling the truth.

In a vigorous dissent, Judge Barkett expressed concern that "the majority reaches the conclusion it does because it suspects that Clausen's lawsuit is without merit," and cautioned that:

> A court should not rely on its estimation of the merits of the underlying suit when deciding whether a complaint has complied with the requirements of Rule 9(b). My concern with the law the Court makes today is that it is undiscriminating, as likely to result in the dismissal of meritorious lawsuits as it is to protect defendants from unwarranted litigation.

Id. at 1316 (Barkett, J., dissenting).

In the present case, the Eleventh Circuit was given the opportunity to clarify its holding in *Clausen*. However, far from limiting *Clausen*'s scope, the court went beyond its holding in *Clausen*, making it even more difficult for a relator to satisfy Rule 9(b). Although *Clausen* required that a complaint contain indicia of reliability to support its allegation that claims were submitted as a result of the fraudulent schemes, it did not place limits on how such reliability could be demonstrated. To the contrary, *Clausen* indicated that indicia of reliability could be provided in a number of ways, including information about "policies about billing or even second-hand information about billing practices." *Id.* at 1312 and n.21.

Unlike the outsider relator in *Clausen*, Relator Corsello was a former employee of the defendants, and alleged familiarity with the defendants' billing policies and practices. In his Second Amended Complaint, Relator Corsello alleged, among other things, that defendants submitted numerous claims for payment that were false because they were based on Certificates of Medical Necessity (CMNs) that had been altered, forged, or otherwise improperly completed. As in *Clausen*, Relator identified a large number of specific claims that were submitted as a result of such schemes, providing the patient initials, the date of the CMN, the manner in which it was altered, and in many cases the person involved in the alteration. SAC, ¶¶ 59, 76, 81, 92.

After the Eleventh Circuit issued its opinion in *Clausen*, adopting the "indicia of reliability" standard, Relator filed a proposed Third Amended Complaint, which added no new claims, but simply provided additional allegations regarding the defendants' billing practices so as to provide additional indicia of reliability for the allegations of claim submission. Among other things, the Third Amended Complaint alleged that it was defendants' practice to submit a claim for payment for every CMN, and that such claims were automatically submitted by the billing departments. TAC, ¶¶ 66, 184, 195-205. The district court refused to allow the filing of the Third Amended Complaint in large part because it did not believe the amendment would satisfy Rule 9(b). App. at 28.

In affirming the district court's holding that Relator's complaints did not satisfy Rule 9(b), the Eleventh Circuit greatly expanded its previous holding in *Clausen*, and rejected the proposition that indicia of reliability could be provided by anything other than *direct* evidence of claims submission:

> Because it is the submission of a fraudulent claim that gives rise to liability under the False Claims Act, that submission must be pleaded with particularity *and not inferred from the circumstances*. . . . Although we construe all facts in favor of the plaintiff when reviewing a motion to

> dismiss, *we decline to make inferences about the submission of fraudulent claims* because such an assumption would "strip[] all meaning from Rule 9(b)'s requirements of specificity." *Clausen, 290* F.3d at 1312 n.21.

App. at 7 (emphasis added). And in explaining why it believed the Third Amended Complaint would not satisfy Rule 9(b), the court indicated that only billing personnel, who have access to billing information for specific claims, may provide the requisite indicia of reliability:

> In addition, the proposed complaint alleged that "sales people do not . . . have access to the specific billing information that is submitted to the government," *which evidenced that the revised complaint still lacked sufficient indicia of reliability*.

App. at 10 (emphasis added).

Thus, the court held that the single fact that Relator was a sales employee, rather than a billing employee, established that he was incapable of providing the requisite indicia of reliability, notwithstanding his extensive allegations showing his familiarity with defendants' billing practices. The Eleventh Circuit thus adopted a *de facto* rule that only direct evidence of claims submission will suffice to satisfy Rule 9(b), effectively limiting the pool of whistleblowers to those persons employed in a defendant's billing department.[2]

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[2] The Eighth Circuit, in a recent case, favorably cited the Eleventh Circuit's "indicia of reliability" test, and held that the relator's allegations lacked credibility in large part because he was not a billing employee. *United States ex rel. Joshi v. St. Luke's Hosp., Inc.*, 2006 U.S. App. LEXIS 5572, *13 (8th Cir. March 6, 2006) (noting that "Dr. Joshi was an anesthesiologist at St. Luke's, not a member of the billing department").

IV. The Eleventh Circuit's approach will have devastating consequences for the False Claims Act, since those whistleblowers best positioned to spot fraud are unlikely to have access to claim-specific billing records.

As discussed above, the primary purpose of the 1986 amendments to the FCA was to induce persons with knowledge of fraud to come forward and file *qui tam* actions. S. Rep. No. 345, 99th Cong. 2d Sess. 6, *reprinted in* 1986 U.S. Code Cong. & Admin. News 5271, 5288-5289 ("The Committee's overall intent in amending the *qui tam* section of the False Claims Act is to encourage more private enforcement suits."). The Eleventh Circuit's approach, as set forth in *Clausen* and expanded in the present case, will seriously undermine this Congressional policy, because there will be few if any employees who will both have knowledge of a defendant's fraud and have access to billing records for particular claims.

As discussed above, the single largest category of *qui tam* cases today consists of healthcare fraud claims, and these types of cases typically involve thousands and thousands of relatively small claims submitted to Medicare or Medicaid over an extended period of time. In most large organizations, the submission of claims for payment is made by a separate billing department, often in a different location from the company's other offices. In the present case, for example, Defendant Lincare had 15 separate regional billing offices, and more than 600 sales offices. TAC, ¶ 198. In almost all cases, claims for Medicare payment are submitted electronically, rather than on paper. *See* 42 C.F.R. § 424.32(d)(2) (requiring electronic submission of most claims). Thus, the act of submitting a claim consists of a billing clerk sending an electronic transmission to the Medicare intermediary. An organization may easily submit thousands or more of such claims for payment every day. Because the claims are submitted electronically, the billing records are stored electronically, and are available only to those persons authorized to access the database – i.e., billing clerks.

In most instances of Medicare and Medicaid fraud, however, a billing clerk will have no idea whether a particular claim – most likely one of hundreds she processes each day – is false. That is because the reason why the claim is false is completely unrelated to the actual submission of the claim, and is not evident from the face of the claim. A billing clerk who receives a batch of claim forms for processing cannot look at a claim and know that the patient's referral was induced by an illegal kickback. A billing clerk will have no way of knowing that the CMN supporting a claim has been forged, altered, or otherwise improperly completed. A billing clerk cannot look at a claim for a laboratory test and know that the test was unnecessary. A billing clerk cannot look at a Medicaid claim for a drug and know that the prescription was induced by the defendant's off-label marketing of the drug. In short, a billing clerk is exceedingly unlikely to have any knowledge that the claims she is submitting are false.

The types of employees who *will* have knowledge that a defendant is committing fraud are likely to be those unconnected with the billing office. A marketing representative, for example, is perfectly positioned to know that the defendant is paying kickbacks to physicians, or is marketing a drug for off-label purposes. A sales representative or middle manager may have knowledge that the defendant is routinely altering CMNs to make a claim payable by Medicare. To use the term employed by many courts, such employees are perfectly placed to gain knowledge of the defendant's "fraudulent schemes." It is precisely these sorts of employees that Congress, in passing the 1986 amendments, wanted to incentivize to bring their information forward.

What these employees will not have, however, is access to the electronic billing records showing that individual claims for specific patients have been submitted for payment to Medicare or Medicaid. Under the Eleventh Circuit's decision in this case, which holds that claim submission may never be established by inference, but only by direct evidence, such employees will thus be unable to provide the requisite indicia of reliability

necessary to satisfy Rule 9(b). As a result, these employees will be unlikely to take the substantial risks that are involved in coming forward with evidence that their employer is committing fraud against the American taxpayers.

It is clear that the Eleventh Circuit's approach will extract a great cost, since rarely, if ever, will a potential whistleblower be so placed as to have his hands on "both ends of the elephant" – the head, where the fraudulent schemes are designed and implemented, and the tail, where the individual claims for payment are submitted. What is equally clear is that the Eleventh Circuit's restrictive interpretation will do nothing to further the purposes of Rule 9(b).

It has been noted that Rule 9(b) serves two primary purposes: it provides notice to the defendant of what it is being accused of, and it serves to protect against spurious lawsuits against innocent defendants. *Durham v. Business Management Associates*, 847 F.2d 1505, 1511 (11th Cir. 1988); *see also Clausen*, 290 F.3d at 1313 n.24. Where, as in the present case, the relator provides a detailed description of the fraudulent schemes, and provides examples of specific claims that are alleged to have been submitted pursuant to such schemes, the defendant has clearly been placed on notice of its alleged misconduct, and a requirement that the relator provide additional "indicia of reliability" in support of such allegations does nothing to increase the defendant's awareness.

As to the second purpose, it is true that the Eleventh Circuit's approach will protect defendants against spurious lawsuits, but only because it protects them from *all* lawsuits. The inability of a relator to attach claim forms to a complaint says nothing about the merits of the case, but simply reflects the fact that the defendant has chosen to separate its marketing functions from its billing functions, and to limit employees' access to billing records. As Judge Barkett noted in her dissent in *Clausen*, the Eleventh Circuit's approach "is undiscriminating, as likely to result in the dismissal of meritorious lawsuits as it is to protect

defendants from unwarranted litigation." *Clausen, supra* at 1316 (Barkett, J., dissenting).

Indeed, many of the largest False Claims Act recoveries have involved relators who were not involved in the billing process, and who would not have gained knowledge of the defendants' fraudulent activities if they were mere billers. For example, in *Franklin, supra* – a case where the government declined to intervene – the relator was a former physician employee of Parke-Davis, a division of Warner-Lambert Company. The relator alleged that the defendant paid kickbacks to physicians to prescribe the defendant's drugs, and also improperly marketed the drug Neurontin for off-label uses. *Id.*, 147 F.Supp.2d at 45-46. However, because the defendant was not a billing employee, he was unable to identify specific claims submitted in connection with the improper activities. *Id.* at 48-49. The district court rejected the defendants' contention that the relator was required to identify specific false claims submitted as a result of the fraudulent activities, and denied a motion to dismiss based on Rule 9(b). *Id.* Subsequently, the case settled for $190 million in payments to the federal government and the states. *See* http://www.taf.org/settlements/PfizerMay2004Settlement.pdf; http://www.usdoj.gov/opa/pr/2004/May/04_civ_322.htm.

Similarly, in *Thompson, supra*, the relator was a physician who alleged that Columbia/HCA improperly paid kickbacks to obtain Medicare referrals. Because he was not a billing clerk, however, the relator could not identify the specific claims that were submitted as a result of this conduct. Nevertheless, the court held that the complaint satisfied Rule 9(b), noting that:

> The basic framework, procedures, the nature of the fraudulent scheme, and the financial arrangements and inducements among the parties and physicians that give rise to Relator's belief that fraud has occurred have been alleged with specificity; Plaintiffs are entitled to discovery before being required to list every false claim, its dates, the individuals responsible, and why each patient was not eligible for Medicare.

Id., 20 F.Supp.2d at 1049. Subsequently, Thompson's allegations were settled for more than $225 million. *See* http://www.usdoj.gov/opa/pr/2003/June/03_civ_386.htm.

Under the Eleventh Circuit's interpretation of Rule 9(b), relators Franklin and Thompson would never have been able to bring their FCA actions for the simple reason that they were not billing clerks, but were "merely" persons with knowledge of the underlying fraudulent schemes. Of course, they would not have been able to bring the actions if they *were* billing clerks, since they would have had no knowledge of the improper kickbacks or the off-label promotions.

It is thus clear that the Eleventh Circuit's restrictive approach will not further the goals of Rule 9(b), but will greatly undermine the effectiveness of the False Claims Act as a tool for combating fraud. Additionally, such an approach is directly contrary to this Court's precedents. By adding a requirement that a complaint, in addition to being sufficiently particular, must also be sufficiently "reliable," the Eleventh Circuit has directly contradicted this Court's directive that, in considering a motion to dismiss, "we must accept as true all of the factual allegations contained in the complaint." *Swierkiewicz*, *supra*, 534 U.S. at 508 n.1; *see also Leatherman*, *supra*, 507 U.S. at 164.

Moreover, the Eleventh Circuit's restrictive approach flies in the face of this Court's decision in *Rotella*, which emphasized the "flexibility" of Rule 9(b). Indeed, *Rotella* expressly recognized that Rule 9(b) may be relaxed where relevant information is in the possession of the defendant. It is abundantly clear that, in cases alleging healthcare fraud, the billing information for individual claims, which are submitted and stored electronically, is in the possession of the defendants. Moreover, as discussed above, *Rotella* relied upon authority holding that such relaxation is particularly appropriate where the complaint alleges fraud against third parties. By definition, cases brought under the False Claims Act are alleging fraud, not against the relator, but against a third party, the United States

government. Since the relators are not the victims of the fraud, it is to be expected that they will not have access to claim-specific information in the defendants' possession, although they will have information regarding the circumstances of defendants' fraudulent activities.

In short, the Eleventh Circuit's approach to Rule 9(b) is contrary to this Court's precedents, does nothing to further the purposes of the Rule, and would dramatically curtail the effectiveness of the False Claims Act as a tool for combating fraud. The grant of certiorari is thus necessary to resolve the critically important issue of the proper application of Rule 9(b) in FCA cases.

V. Certiorari is necessary to resolve the threshold issue of whether compliance with Rule 9(b) is always necessary to state a claim under the False Claims Act.

As discussed above, certiorari is necessary to address the proper application of Rule 9(b) to FCA cases. Relator also believes, however, that this Court should address the threshold issue of whether compliance with Rule 9(b) is always necessary to state a claim under the FCA.

Every circuit court that has considered the issue has uncritically accepted that Rule 9(b) applies simply because a case is brought under the False Claims Act. *See Yuhasz v. Brush Wellman, Inc.*, 341 F.3d 559, 562-63 (6th Cir. 2003); *Clausen, supra*, 290 F.3d at 1308-09; *United States ex rel. Totten v. Bombardier Corp.*, 286 F.3d 542, 551-52 (D.C. Cir. 2002); *Bly-Magee v. California*, 236 F.3d 1014, 1018 (9th Cir. 2001); *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 125 F.3d 899, 903 (5th Cir. 1997); *Gold v. Morrison-Knudsen Co.*, 68 F.3d 1475, 1476-77 (2d Cir. 1995); *Karvelas, supra*, 360 F.3d at 227-228.

However, none of these decisions has satisfactorily analyzed the issue. Indeed, courts have rarely offered any analysis beyond the broad assertion that the FCA is an "anti-fraud" statute. *See, e.g., Gold*, 68 F.3d at 1476 ("It is self-evident that the FCA is an anti-fraud statute");

Bly-Magee, 236 F.3d at 1018 ("The FCA is an anti-fraud statute"). As discussed below, it is true that the FCA is an anti-fraud statute, but it is not *solely* an anti-fraud statute, and a relator may prove an FCA violation without proving fraud. Under well-established authority, if fraud is not a required element of a cause of action, the failure of an averment to satisfy Rule 9(b) does not mean that a plaintiff has failed to state a claim. Accordingly, certiorari is warranted to clarify the proper relationship between Rule 9(b) and the FCA.

A. The FCA does not require proof of fraud.

Rule 9(b) states that "[i]n all averments of fraud . . . , the circumstances constituting fraud . . . shall be stated with particularity." Thus, by virtue of its very language, the rule applies only to "averments of fraud," and as to those "averments," only the "circumstances constituting fraud" need be stated with particularity. Rule 9(b) thus does not require that all facts creating a cause of action be stated with particularity – it only requires particularity with respect to those circumstances that constitute fraud. *See* 2 Moore's Federal Practice, 3d ed., § 9 App. 01 (1998) ("Rule 9 does not require certain averments of facts constituting a cause of action. . . . Rather, the provisions simply require more specificity for certain averments, including . . . the circumstances constituting fraud.").

If Rule 9(b) automatically applies to all cases brought under the False Claims Act, therefore, it can only be because such cases require an "averment of fraud." The False Claims Act, however, does *not* require a plaintiff to prove fraud. Rather, the act imposes liability on any person who "knowingly presents, or causes to be presented, to an officer or employee of the United States Government . . . a false or fraudulent claim for payment or approval." 31 U.S.C. § 3729(a)(1). Thus, it is not required that the claim be fraudulent, but simply that it be false. *See United States v. TDC Management Corp., Inc.*, 24 F.3d 292, 297 (D.C. Cir. 1994) (concluding that "Congress distinguished 'false' from 'fraudulent' claims and presum[ing] the distinction to turn

on whether the defendant acted with an intent to deceive"). And with respect to the "knowing" requirement, the 1986 amendments to the FCA specifically provided that "no proof of specific intent to defraud is required," and that a person acts knowingly if he acts in "deliberate ignorance" or in "reckless disregard" of the truth or falsity of information. 31 U.S.C. § 3729(b).

It is clear that, in imposing liability where a defendant acts with "reckless disregard" or with "deliberate ignorance" of the truth or falsity of information, the False Claims Act imposes liability for actions that would not constitute "fraud," as that term is generally understood. As one of the sponsors of the 1986 amendments stated:

> Subsection 3 of Section 3729(c) uses the term "reckless disregard of the truth or falsity of the information" which is no different than and has the same meaning as a gross negligence standard that has been applied in other cases. While the Act was not intended to apply to mere negligence, it is intended to apply in situations that could be considered gross negligence where the submitted claims to the Government are prepared in such a sloppy or unsupervised fashion that resulted in overcharges to the Government. The Act is also intended not to permit artful defense counsel to require some form of intent as an essential ingredient of proof. This section is intended to reach the "ostrich-with-his-head-in-the-sand" problem where government contractors hide behind the fact they were not personally aware that such overcharges may have occurred.

132 Cong. Rec. H9382-03 (daily ed. Oct. 7, 1986) (statement of Rep. Berman), *quoted in United States v. Krizek*, 111 F.3d 934 (D.C. Cir. 1997).

In *Krizek*, the D.C. Circuit noted that the phrase "reckless disregard" is sometimes used "as a proxy for forbidden intent," while at other times it is "'simply a linear extension of gross negligence, a palpable failure to meet the appropriate standard of care.'" *Id.* at 941, *quoting Saba v. Compagnie Nationale Air France*, 78 F.3d 664,

668 (D.C. Cir. 1996). The court concluded that, as used in the False Claims Act, "reckless disregard" is best understood as "an extension of gross negligence." *Krizek*, *supra* at 942; *see also United States ex rel. Augustine v. Century Health Services, Inc.*, 136 F.Supp.2d 876, 887-88 (M.D. Tenn. 2000) ("[R]eckless disregard has been construed as 'an extreme version of ordinary negligence' rather than as a 'lesser form of intent.'"). It is thus clear that the knowledge requirement set forth in the False Claims Act is closer to a negligence standard than to a scienter standard. *See United States v. Mackby*, 261 F.3d 821, 828 (9th Cir. 2001) (medical clinic's owner "acted in reckless disregard or in deliberate ignorance" by "failing to inform himself of [Medicare] requirements" before submitting claims for payment); *UMC Electronics Co. v. U.S.*, 43 Fed.Cl. 776, 794 (Fed. Cl. 1999) (contractor submitting claim "has a duty to examine its records to determine what amounts the government already has paid or whether payments are actually owed to subcontractors or vendors," and failure to do so "constitutes deliberate ignorance or reckless disregard"); *Wilkins ex rel. U.S. v. State of Ohio*, 885 F.Supp. 1055, 1060 (S.D. Ohio 1995) ("the [FCA's] scienter requirement is something less than the elements of fraud at common law").

Since the type of knowledge required to prove an FCA claim is not a lesser form of "intent" or "scienter," but is rather a heightened version of negligence, an allegation of such knowledge is not an "averment of fraud." Rather, an FCA claim alleging reckless disregard or deliberate ignorance is more in the nature of a claim for negligent misrepresentation. And it has been widely held that the pleading requirements of Rule 9(b) do not apply to claims of negligent misrepresentation. *See Am. Realty Trust, Inc. v. Hamilton Lane Advisors, Inc.*, 115 Fed. Appx. 662, 669 n.30 (5th Cir. 2004); *Sparling v. Daou (In re Daou Sys.)*, 411 F.3d 1006, 1028 (9th Cir. 2005).

It is thus clear that, although an averment of fraud will *suffice* to establish liability under the False Claims Act, it is not *necessary* to establish such liability. In other words, it is possible for a relator to prove an FCA claim

without proving that the defendant committed acts constituting "fraud." As this Court held in *Swierkiewicz,* 534 U.S. at 511-512, "[i]t . . . seems incongruous to require a plaintiff, in order to survive a motion to dismiss, to plead more facts than he may ultimately need to prove to succeed on the merits." Accordingly, a plaintiff need not make an averment of fraud in order to state a claim under the FCA.

B. Where fraud is not an essential element of a claim, failure to satisfy Rule 9(b) is not necessarily fatal.

This is not to state that Rule 9(b) has no application whatsoever to the False Claims Act. Quite plainly, many FCA cases will be based on actions that constitute fraud. If an FCA complaint does make an averment of fraud, Rule 9(b) would require that averment to be stated with particularity. However, that does not change the fact that a plaintiff may state a valid FCA case without making such an averment.

The False Claims Act is not the only statute which allows, but does not require, proof of fraud in order to establish liability. Section 11 of the 1933 Securities Act creates a cause of action for the purchaser of a security if the registration statement contained a material omission or misrepresentation. 15 U.S.C. § 77k(a). In considering this statute, circuit courts have held that the proper approach is not to simply require all complaints brought under the statute to comply with Rule 9(b). As the Eighth Circuit noted:

> The only consequence of a holding that Rule 9(b) is violated with respect to a § 11 claim would be that any allegations of fraud would be stripped from the claim. The allegations of innocent or negligent misrepresentation, which are at the heart of a § 11 claim, would survive. The plaintiffs' case should not have been dismissed because they alleged more than was necessary to recover under § 11 of the Securities Act.

Carlon v. Thaman (In re NationsMart Corp. Sec. Litig.), 130 F.3d 309, 315 (8th Cir. 1997). Similarly, the Fifth Circuit has held that:

> Where averments of fraud are made in a claim in which fraud is not an element, an inadequate averment of fraud does not mean that no claim has been stated. The proper route is to disregard averments of fraud not meeting Rule 9(b)'s standard and then ask whether a claim has been stated.

Lone Star Ladies Inv. Club v. Schlotzsky's Inc., 238 F.3d 363, 368 (5th Cir. 2001).

In *Vess v. Ciba-Geigy Corp. USA*, 317 F.3d 1097, 1105 (9th Cir. 2003), the Ninth Circuit considered the application of Rule 9(b) to a state cause of action for which fraud was not an essential element. The Court held that:

> in a case where fraud is not an essential element of a claim, only allegations ("averments") of fraudulent conduct must satisfy the heightened pleading requirements of Rule 9(b). Allegations of non-fraudulent conduct need satisfy only the ordinary notice pleading standards of Rule 8(a). . . . Thus, if particular averments of fraud are insufficiently pled under Rule 9(b), a district court should "disregard" those averments, or "strip" them from the claim. The court should then examine the allegations that remain to determine whether they state a claim.

Id., 1104-1105.

Rather than applying this sophisticated approach to False Claims Act cases, the circuit courts have simply held that, in any action brought under the FCA, the complaint must comply with Rule 9(b). These courts have thus completely failed to recognize that it is possible to state a claim under the FCA without making an averment of fraud – in effect, the courts have judiciously stricken from the statute those provisions imposing liability on defendants for acts that do not constitute fraud. Such an approach is directly contrary to this Court's precedents in

Leatherman and *Swierkiewicz*, which have recognized that Rule 9(b) is not to be applied beyond its strict limits. As this Court has stated, "A requirement of greater specificity for particular claims is a result that 'must be obtained by the process of amending the Federal Rules, and not by judicial interpretation.'" *Swierkiewicz,* 534 U.S. at 515, *quoting Leatherman*, 507 U.S. at 168.

Given the FCA's importance as the nation's primary tool for combating government fraud, and given the enormous impact Rule 9(b) has had on cases brought under the FCA, this Court should grant certiorari to clarify the proper relationship between Rule 9(b) and the False Claims Act.

CONCLUSION

The Petition for a Writ of Certiorari should be granted.

Respectfully submitted.

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Counsel for Petitioner

[PUBLISH]

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 05-11868
Non-Argument Calendar

D.C. Docket No. 98-00204-CV-ODE-1

KIRK S. CORSELLO,

Plaintiff-Appellant,

versus

LINCARE, INC.,
LINCARE HOLDINGS, INC.,
ROTECH, INC.,
ALAN VARRAUX, M.D.,
ROTECH MEDICAL
CORPORATION,

Defendants-Appellees,

LINCARE HEALTHCARE
GROUP, INC., AMERICAN
HOME PATIENT, INC., et al.,

Defendants.

Appeal from the United States District Court
for the Northern District of Georgia

(October 20, 2005)

Before TJOFLAT, DUBINA and PRYOR, Circuit Judges.

PER CURIAM:

The issue in this *qui tam* action, brought under the False Claims Act, is whether a former sales employee of multiple defendants pleaded fraud with particularity, under Federal Rule of Civil Procedure 9(b), by baldly asserting that improper practices "resulted in the submission of false claims." Kirk S. Corsello appeals both the dismissal of his complaint for failure to plead fraud with particularity and the denial of his motion to file a third amended complaint. Because the complaint failed to provide any factual support that false claims were actually submitted to the government and a third amendment of the complaint more than five years after the commencement of this action would have been futile, we affirm.

I. BACKGROUND

In 1998, Corsello brought a *qui tam* action under the False Claims Act against 56 entities and 99 John Does and John Doe Corporations. Corsello alleged that while he was employed by two of the defendants, they engaged in various fraudulent schemes, including paying illegal kickbacks to physicians to induce referrals, falsifying certificates of medical necessity to provide unnecessary treatment, and billing for unnecessary or non-existent treatment to obtain Medicare payments unlawfully. Corsello failed to serve process on the defendants with his original complaint, but instead moved to file an amended complaint. On June 18, 1999, the district court granted Corsello's motion to file an amended complaint but warned Corsello that "[t]he *Qui Tam* Act was not enacted in order to give the relator an unlimited opportunity to perfect its complaint" and that "the amended complaint shall fully

comport with the requirement of [Federal Rule of Civil Procedure 9(b)]." Corsello served the first amended complaint on July 18, 1999, but then filed a second amended complaint on January 13, 2000, to cure some of the deficiencies in his earlier complaints and further reduce the number of defendants.

In his amended complaint, Corsello alleged that Lincare, Inc., Lincare Holdings, Inc., Rotech, Inc., Alan Varraux, M.D., Rotech Medical Corporation, and American Home Patient, Inc., violated the False Claims Act by submitting false Medicare claims and conspiring to defraud the government. 31 U.S.C. § 3729(a)(1), (a)(2), (a)(3). Lincare, Inc., and Lincare Holdings, Inc. (collectively Lincare), Rotech, Inc., and Rotech Medical Corporation (collectively Rotech), and American Home Patient, Inc., are nationwide providers of oxygen services and equipment to patients in their homes. Varraux is a physician specializing in pulmonology. Corsello was employed by Lincare as the Center Manager for the South Orlando Center from 1995 to 1997. After Corsello was terminated by Lincare, he worked for Rotech as a Regional Sales Support employee from 1998 until his termination in 1999.

On March 9, 2001, the district court granted a motion to dismiss Corsello's claims against Lincare, American Home Patient, Inc., and Varraux because Corsello failed to plead fraud with particularity. Corsello appealed, but this Court dismissed the appeal because the district court had not yet adjudicated Corsello's claims against Rotech. Rotech then moved to dismiss the second amended complaint for failure to state a claim. Corsello responded to Rotech's motion to dismiss and proposed to file a third amended complaint. The district court granted the motion to dismiss on the ground that Corsello's complaint failed to

plead fraud with particularity. The district court also denied Corsello's motion to file a third amended complaint because Corsello had waited over a year since the dismissal of his claims against the other defendants, had not explained why he did not plead the necessary facts in the previous versions of his complaint, and had not offered an amendment that cured the deficiencies of his complaint.

II. STANDARD OF REVIEW

This appeal is governed by two standards of review. First, this Court reviews *de novo* a dismissal for failure to state a claim upon which relief may be granted. *United States ex rel. Clausen v. Lab. Corp. of Am., Inc.*, 290 F.3d 1301, 1307 n. 11 (11th Cir. 2002). On a motion to dismiss for failure to state a claim, we accept as true the facts as alleged in the complaint. *Id.* at 1303 n.2. Second, we review the denial of a motion to amend a complaint for abuse of discretion. *Bryant v. Dupree*, 252 F.3d 1161, 1163 (11th Cir. 2001). The underlying legal conclusion of whether a particular amendment to the complaint would have been futile is reviewed *de novo*. *See Harris v. Ivax Corp.*, 182 F.3d 799, 802-03 (11th Cir. 1999).

III. DISCUSSION

Corsello appeals both the dismissal of his complaint and the denial of his motion to amend the complaint. We first consider whether the district court erred in dismissing Corsello's claims under the False Claims Act for failure to plead fraud with particularity. We then address whether the district court erred in denying Corsello's motion to file a third amended complaint.

A. The District Court Correctly Dismissed the Complaint for Failure to Comply with Rule 9(b)

Sections 3729(a)(1) and (a)(2) of the False Claims Act subject to civil liability entities that knowingly submit false or fraudulent claims to the government for payment or approval. *Clausen*, 290 F.3d at 1309. Liability under the False Claims Act arises from the submission of a fraudulent claim to the government, not the disregard of government regulations or failure to maintain proper internal policies. *Id.* at 1311. The act of submitting a fraudulent claim to the government is the "*sine qua non* of a False Claims Act violation." *Id.* This Court has held that complaints alleging violations of the False Claims Act are governed by Rule 9(b). *Clausen*, 290 F.3d at 1308-09.

Under Rule 9(b), "the circumstances constituting fraud or mistake shall be stated with particularity." Fed. R. Civ. P. 9(b). To state a claim under the False Claims Act with particularity, the complaint must allege " 'facts as to time, place, and substance of the defendant's alleged fraud,' [and] 'the details of the defendants' allegedly fraudulent acts, when they occurred, and who engaged in them.' " *Clausen*, 290 F.3d at 1310 (citing *Cooper v. Blue Cross & Blue Shield of Fla., Inc.*, 19 F.3d 562, 567-68 (11th Cir. 1994)). Failure to satisfy Rule 9(b) is a ground for dismissal of a complaint.

In *Clausen*, we stated that the complaint must contain "some indicia of reliability" to satisfy Rule 9(b). 290 F.3d at 1311. In that case, Clausen, who was a competitor of the defendant, brought an action under the False Claims Act and alleged that the defendant had engaged in a "decade-long campaign to defraud the Government." *Id.* at 1302-03. Although Clausen described in detail a private scheme to

defraud, Clausen's complaint did not provide "any billing information to support [Clausen's] allegation that actual false claims were submitted for payment." *Id.* at 1306. The complaint speculated that claims "must have been submitted, were likely submitted or should have been submitted to the Government." *Id.* at 1311. The complaint did not contain any "stated reason for [Clausen's] belief that claims requesting illegal payments must have been submitted." Because Clausen was a "corporate outsider," his failure to include a credible set of facts to support his vague allegations rendered his complaint deficient under Rule 9(b). *Id.*

In *Hill v. Morehouse Medical Associates*, an unpublished opinion, we elaborated on the "indicia of reliability" required by *Clausen*. No. 02-14429 (11th Cir. Aug. 15, 2003) (per curiam). Hill, who was a former employee in the billing department of the defendant, alleged a billing process and details about five fraudulent billing schemes the defendant used to submit claims to the government. *Id.* Unlike the relator in *Clausen*, who was a "corporate outsider," Hill had "firsthand information" about the billing practices of the defendant. *Id.* at 5. Because Hill "worked in the very department where she alleged the fraudulent billing schemes occurred," her allegations that fraudulent claims were submitted on a daily basis were factually credible. This Court held that Hill's complaint satisfied Rule 9(b) because Hill was "privy to . . . the internal billing practices" of the defendant and thus provided factual support for the allegations of fraudulent billing in her complaint. *Id.* at 5.

Corsello is neither a "corporate outsider" nor an employee in the billing department. Corsello contends that he is unlike the relator in *Clausen* because, as a sales

employee, he was "aware" of the manner by which the defendants submitted fraudulent claims and had "learned from his colleagues the national reach of the schemes." Corsello also argues that his second amended complaint, like the complaint in *Hill*, contained "indicia of reliability" to satisfy Rule 9(b) because the complaint alleged many details of numerous schemes, employees, and claims. Corsello argues that the complaint provided the initials of patients whose Medicare forms were improperly completed and eventually, Corsello alleged, "resulted in the submission of fraudulent claims."

Corsello argues that a pattern of improper practices of the defendants leads to the inference that fraudulent claims were submitted to the government, but we disagree. Because it is the submission of a fraudulent claim that gives rise to liability under the False Claims Act, that submission must be pleaded with particularity and not inferred from the circumstances. *See* Fed. R. Civ. P. 9(b) (stating that "the circumstances constituting fraud . . . shall be stated with particularity"). Although we construe all facts in favor of the plaintiff when reviewing a motion to dismiss, we decline to make inferences about the submission of fraudulent claims because such an assumption would "strip[] all meaning from Rule 9(b)'s requirements of specificity." *Clausen*, 290 F.3d at 1312 n.21.

Corsello's complaint failed to satisfy 9(b). Corsello's second amended complaint failed to allege when, where, and what violations of the False Claims Act occurred. The complaint instead used vague allegations that improper practices took place "everywhere Lincare does business throughout the statutory time period." The allegations also failed to provide a factual basis to conclude fraudulent claims were ever actually submitted to the government in

violation of the False Claims Act. At best, Corsello alleged that improper practices have "resulted in the submission of fraudulent claims," or "lead directly to the submission of fraudulent claims."

Although Corsello worked in sales, his allegations, often based "on information and belief," lacked the "indicia of reliability" required by *Clausen* because they failed to provide an underlying basis for Corsello's assertions. Corsello did not explain why he believes fraudulent claims were ultimately submitted. Corsello's contention that he was "aware" of billing practices was neither particular to any specific fraudulent claim against the government nor factually supported because Corsello conceded that he "did not have access to company files outside his own offices." Underlying improper practices alone are insufficient to state a claim under the False Claims Act absent allegations that a specific fraudulent claim was in fact submitted to the government. *Clausen*, 290 F.3d at 1311. In short, Corsello provided the "who," "what," "where," "when," and "how" of improper practices, but he failed to allege the "who," "what," "where," "when," and "how" of fraudulent submissions to the government.

Corsello's allegation that the defendants conspired to defraud the government in violation of section 3729(a)(3) of the False Claims Act likewise failed to satisfy the requirements of Rule 9(b). To state a claim under section 3729(a)(3), the plaintiff must show "(1) that the defendant conspired with one or more persons to get a false or fraudulent claim paid by the United States; (2) that one or more of the conspirators performed any act to effect the object of the conspiracy; and (3) that the United States suffered damages as a result of the false or fraudulent claim." *United States ex rel. Stinson v. Provident Life &*

Accident Ins. Co., 721 F. Supp. 1247, 1259 (S.D. Fla. 1989). Section 3729(a)(3) of the False Claims Act imposes liability on those who "conspire[] to defraud the government by getting a false or fraudulent claim allowed or paid." 31 U.S.C. § 3729(a)(3). In his second amended complaint, Corsello alleged that "Lincare and Varraux conspired to defraud the Government," but this bare legal conclusion was unsupported by specific allegations of any agreement or overt act. The district court correctly dismissed Corsello's complaint for failure to comply with Rule 9(b).

B. The District Court Did Not Abuse Its Discretion When It Denied Corsello's Motion to File a Third Amended Complaint

Corsello also argues that the district court erred when it denied his motion to file a third amended complaint. Under Federal Rule of Civil Procedure 15(a), a court should give leave to amend freely "when justice so requires." Fed. R. Civ. P. 15(a). Ordinarily, a party must be given at least one opportunity to amend before the district court dismisses the complaint. *Bryant v. Dupree*, 252 F.3d 1161, 1163 (11th Cir. 2001). The district court, however, need not "allow an amendment (1) where there has been undue delay, bad faith, dilatory motive, or repeated failure to cure deficiencies by amendments previously allowed; (2) where allowing amendment would cause undue prejudice to the opposing party; or (3) where amendment would be futile." *Id.*

The district court did not abuse its discretion when it denied Corsello's motion to amend his complaint. Allowing another amendment would have led to the filing of Corsello's fourth complaint in over five years of litigation. Corsello proposed to file his third amended complaint

eighteen months after the district court had dismissed Corsello's claims against Lincare, American Home Patient, and Varraux. The district court had warned Corsello from the beginning that he must plead fraud with particularity and was not required to give Corsello another opportunity to correct his errors. Corsello's "repeated failure to cure deficiencies by [previous] amendments" is an explicitly permitted reason for which the district court was entitled to deny his motion to amend. *See id.*

Corsello erroneously argues that the motion to file a third amended complaint was delayed because of our decision in *Clausen*. Corsello does not explain why he moved to amend five months after the *Clausen* decision was issued. Moreover, *Clausen* did not articulate a new standard that required an extensive amendment to Corsello's complaint; *Clausen* interpreted an existing standard that Corsello had failed to meet.

The district court also did not err when it determined that allowing Corsello to amend his complaint would have been futile, because Corsello's proposed complaint still failed to meet the standard of Rule 9(b). The deficiencies of the second amended complaint remained in the proposed complaint: the allegations of the proposed complaint were unlimited in temporal or geographic scope and failed to plead specific instances of fraudulent submissions to the government. In addition, the proposed complaint alleged that "sales people do not . . . have access to the specific billing information that is submitted to the government," which evidenced that the revised complaint still lacked sufficient indicia of reliability. The district court, therefore, did not abuse its discretion when it denied Corsello's motion to amend.

IV. CONCLUSION

Because Corsello's complaint failed to plead fraud with particularity and the district court did not abuse its discretion when it denied Corsello's motion to file a third amended complaint, the dismissal of Corsello's second amended complaint and the denial of his motion to amend that complaint are

AFFIRMED.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA ex rel. KIRK S. CORSELLO and KIRK S. CORSELLO, Plaintiffs v. LINCARE, INC., LINCARE HOLDINGS INC., AMERICAN HOMEPATIENT, INC., ROTECH INC., and ALAN VARRAUX, M.D., Defendants	CIVIL ACTION NO. 1:98-CV-0204-ODE

ORDER

(Filed Jun. 2, 2003)

This *qui tam* civil action, filed pursuant to the False Claims Act, 31 U.S.C. § 3729 *et seq.*, is before the Court on Defendant Rotech Inc.'s motion to dismiss Relator Corsello's second amended complaint and Relator Corsello's motion for relief from the Court's order dismissing the second amended complaint with regard to Defendants Lincare, Inc., Lincare Holdings Inc., American HomePatient, Inc. and Alan Varraux and motion to amend the second amended complaint. For the reasons stated below, Defendant's motion to dismiss is GRANTED in part and DENIED in part; Relator's motion for relief from the Court's order dismissing the second amended complaint with regard to Defendants Lincare, Inc., Lincare Holdings Inc., American HomePatient, Inc. and Alan Varraux is

GRANTED in part and DENIED in part; and Relator's motion to amend the second amended complaint is DENIED.

I. Background

Relator brought this action on January 22, 1998, under the False Claims Act, 31 U.S.C. § 3729 *et seq.* Relator alleges that Defendants engaged in Medicare fraud against the United States government through various fraudulent schemes designed to obtain Medicare payments unlawfully. Relator further alleges that he was illegally terminated in retaliation for the filing of this suit. The United States has not intervened in this case.

On June 18, 1999, this Court granted Relator's motion to file an amended complaint. Relator served his first amended complaint on July 14, 1999. In an apparent attempt to cure some of the deficiencies in his first amended complaint, Relator then filed a second amended complaint on January 13, 2000, reducing the number of named defendants[1] to include Lincare, Inc., Lincare Holdings Inc., Rotech Medical Corporation, American HomePatient, Inc., and Dr. Alan Varraux.

Lincare Inc. and Lincare Holdings Inc. ["Lincare"],[2] American HomePatient, and Rotech are nationwide providers of durable medical equipment and home health

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[1] Originally, Relator named fifty-six entities and ninety-nine John Doe(s) and John Doe corporations as defendants.

[2] In his pleadings, Relator refers to Lincare, Inc. and Lincare Holdings, Inc. collectively as "Lincare." Because it is impossible to ascertain to which Lincare entity Relator refers, the Court will likewise refer to both entities collectively.

services. Varraux is a physician specializing in pulmonology who allegedly had a medical director agreement with Lincare. Relator states that he was employed by Lincare as a Center Manager for the south Orlando Center from August 15, 1995 through December 19, 1997. Compl. ¶ 5. Additionally, Relator asserts that he was employed by Rotech as a Regional Sales Support person from August, 1998, through November 4, 1999. *Id.* Based upon information allegedly obtained during his employment with Lincare and Rotech, Relator asserts that Defendants engaged in various schemes resulting in violations of the False Claims Act.

In his second amended complaint, Relator asserts three counts of False Claims Act violations based on these allegedly fraudulent schemes. In Count I, Relator alleges that all Defendants violated 31 U.S.C. § 3729(a)(1) and (a)(2)[3] by presenting false claims for payment and by submitting false records or statements for the purpose of payment of false claims. *See* Compl. ¶¶ 189-96. In Count

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[3] In relevant part, 31 U.S.C. § 3729(a) provides:

> Any person who –
>
> (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;
>
> (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;
>
> (3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid; . . . is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person. . . .

II, Relator alleges that Defendant Lincare terminated him in violation of 31 U.S.C. § 3730(h).[4] *See id.* ¶¶ 197-200. Count III is an identical retaliation claim against Defendant Rotech. *See* Compl. ¶ 201-04.

Lincare and American HomePatient each filed separate motions to dismiss pursuant to Federal Rules of Civil Procedure 9(b) and 12(b)(6). Varraux, proceeding *pro se*, adopted Lincare's motion to dismiss pursuant to Federal Rules of Civil Procedure 9(b) and 12(b)(6). In an order dated March 29, 2001, the undersigned granted these motions to dismiss, finding that Relator had failed to plead fraud with particularity as mandated by Federal Rule of Civil Procedure 9(b) and as previously directed by this Court.[5]

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[4] In relevant part, section 3730(h) provides:

> Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate district court of the United States for the relief provided in this subsection.

[5] In the order granting Relator's motion to file an amended complaint, the Court cautioned Relator as follows:

> The *Qui Tam* Act was not enacted in order to give the relator an unlimited opportunity to perfect its complaint or the

(Continued on following page)

II. Defendant Rotech's Motion to Dismiss

Defendant Rotech, having filed a notice of bankruptcy stay on February 25, 2000, did not file a motion to dismiss at that time. According to Rotech, its reorganization plan was confirmed by the Bankruptcy Court for the District of Delaware on February 13, 2002, and the stay has now been terminated. In its currently pending motion to dismiss, Defendant Rotech argues that because the allegations against it are almost identical to the allegations raised against Defendants Lincare and American HomePatient, Inc., the allegations against Defendant Rotech must also be dismissed. While the Federal Rules of Civil Procedure generally require in a complaint only a short and plain statement of the cause of action, Rule 9(b) states that "[i]n all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity. Malice, intent, knowledge, and other condition of a mind of a person may be averred generally." Fed.R.Civ.P. 9(b). In addition to providing adequate notice to enable defendants to frame a response, this heightened

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government an unlimited opportunity to elect to intervene. However, in consideration of judicial economy and in light of the fact that none of the parties to this action have yet been served, the court hereby GRANTS Plaintiff's motion for leave to amend the complaint. Plaintiff shall submit an amended complaint within ten (10) days of the entry of this order. The amended complaint shall fully comport with the requirement of Fed.R.Civ.P. 9(b), which requires that fraud be plead with specificity. The plaintiffs complaint must allege the details of the defendant's allegedly fraudulent acts, when they occurred, and who engaged in them. *Cooper v. Blue Cross and Blue Shield of Florida*, 19 F.3d 562, 568 (11th Cir. 1994). There will be no further extensions of time.

United States ex rel. Corsello v. Lincare. Inc., No. 1:98-CV-0204-ODE, slip op. at 2 (N.D. Ga. June 18, 1999).

standard serves to protect defendants from frivolous suits, to preclude fraud actions based upon facts obtained through discovery after the complaint is filed, and to prevent the damage to the goodwill and reputation of defendants that may result from even meritless claims. *U.S. ex rel. Stinson, Lyons, Gerlin & Bustamante, P.A. v. Blue Cross Blue Shield of Ga., Inc.*, 755 F.Supp. 1040, 1053 (S.D. Ga. 1990). Rule 9(b) may be satisfied if the complaint sets forth:

> (1) precisely what statements were made in what documents or oral representations or what omissions were made, and
>
> (2) the time and place of each such statement and the person responsible for making (or, in the case of omissions, not making) same, and
>
> (3) the content of such statements and the manner in which they misled the plaintiff, and
>
> (4) what the defendants "obtained as a consequence of the fraud.

Brooks v. Blue Cross and Blue Shield of Fla., Inc., 116 F.3d 1364, 1371 (11th Cir. 1997) (citations omitted); *see also Leonard v. Stuzzi-James Co., Inc.*, 742 F.Supp. 653, 659 (N.D. Ga. 1990) (granting motion to dismiss where complaint failed to allege "specifically when, where, by whom, or specifically what the representation was").

Applying this standard, this Court finds that Relators second amended complaint as against Defendant Rotech falls short of compliance with the requirements of Rule 9(b). Relator alleges that Defendant Rotech employed the following methods to defraud the Medicare system: (1) improper testing and qualification of patients for certain services by falsifying diagnoses and/or test results,

manipulating tests to achieve a qualifying result, and qualification of patients by Defendants rather than an independent medical practitioner; (2) delivery of excess and unneeded unit dose medications; (3) re-renting equipment which has already been fully paid for by Medicare (referred to as "capped" equipment); (4) billing Medicare for durable medical equipment (DME) no longer in use by the patient; (5) charging Medicare more than private insurance companies are charged for the same services; (6) "unbundling" prescriptions for respiratory medicines so that Defendants could bill the government for the medicines separately; (7) converting Medicare patients to motorized wheelchairs, regardless of medical necessity, which can be billed at a higher rate; and (8) billing Medicare for nursing home patients in Oklahoma that did not exist. Relator alleges that Defendants engaged in the following schemes to circumvent the statutory safeguards intended to prevent these types of fraudulent claims: (1) kickbacks to physicians to induce referrals and falsification of documentation; (2) waiver of patients' 20% co-payment for oxygen services in the absence of any hardship to avoid patients, objections to overcharges or unnecessary equipment or medicine; (3) falsification, forgery, or illegal completion of certificates of medical necessity ["CMN"] to enable the provision of unnecessary treatment and services; and (4) "trolling" for Medicare patients by reviewing physician files to identify patients who may be eligible for oxygen services.

However, Relator never sufficiently alleges the submission of a false claim for payment to the government, the sine qua non of a False Claims Act violation. Instead, Relator seeks to frame his False Claims Act suit by generally alleging fraudulent practices which, in theory, could

lead to the submission of false claims. This manner of pleading is not contemplated by the False Claims Act. *U.S. ex rel. Clausen v. Lab. Corp. of Am., Inc.*, 290 F.3d 1301 (2002) (upholding dismissal of False Claims Act count for failure to specify when and through which procedure each false claim was submitted for payment).

In *Clausen,* the United States Court of Appeals for the Eleventh Circuit clearly establishes the specificity required of False Claims Act allegations:

> Rule 9(b)[ ] . . . does not permit a False Claim Act plaintiff merely to describe a private scheme in detail but then to allege simply and without any stated reason for his belief that claims requesting illegal payments must have been submitted, were likely submitted or should have been submitted to the Government. . . . [I]f Rule 9(b) is to be adhered to, some indicia of reliability must be given in the complaint to support the allegation of *an actual false claim* for payment being made to the Government.

Id. at 1311. This standard may be satisfied by information such as the amount and actual dates of submitted charges, policies about billing or even second-handed information about billing practices, or copies of bills or payments. *Id.* at 1312. While not all of these details are required, "some of this information for at least some of the claims must be pleaded in order to satisfy Rule 9(b)." *Id.* at 1312 n.21.

The sparse details contained in the instant complaint do not adequately specify the what, when, and where of any claim submission. Instead, Relator alleges generally that Defendant Rotech provided services to Medicare patients and was required to obtain certain documentation – namely, the CMNs – to be reimbursed for such services.

Relator goes on to specifically allege facts surrounding the falsification of such documentation. For example, Relator alleges that Rotech made direct cash payments to referring physicians and/or members of their staff in Texas from December 1996 through January 1999 to induce referrals or the falsification of documentation. Compl. ¶ 25. Although Relator cites four doctors and two Defendant employees who allegedly engaged in the kickback scheme, this example does not adequately support an allegation otherwise unlimited in time and geography that Defendants used the kickback scheme to submit false claims. Nor are Relator's allegations with respect to the provision of free or below market tests and services sufficiently specific. Relator alleges that two Rotech employees indicated that they would offer to provide free services to medical professionals but allow the professionals to bill for the services. *Id.* ¶ 29. However, Relator fails to allege that the free services were actually provided or that the medical professionals submitted fraudulent bills based on these services. Relator further alleges that Defendant entered into medical director agreements with two referring physicians in Texas who allegedly received "a monthly fee" pursuant to this referral scheme. *Id.*, ¶ 44. Given the breadth of the allegation, this solitary detail is not adequate.

In any case, even if sufficient facts were alleged to support these claims that such schemes existed, Relator's failure to allege the presentation of a false claim precludes liability under the False Claims Act for such acts. *Clausen,* 290 F.3d at 1313 n.24. Relator alleges that based on his personal experience, Rotech provided equipment and services to patients pursuant to CMNs, *see* Compl. ¶¶ 13, 23, 53, 60-63, 65, and that Rotech was required to obtain

CMNs to obtain reimbursement for the provision of equipment and services to government aid recipients. *Id.* ¶¶ 18-20, 52. However, that Rotech provided services pursuant to CMNs and that CMNs were required for reimbursement does not, without more, establish that Rotech submitted false claims. "The False Claims Act does not create liability merely for a health care providers disregard of Government regulations or improper internal policies unless, as a result of such acts, the provider knowingly asks the Government to pay amounts it does not owe." *Clausen,* 290 F.3d at 1311. Relator fails to make the necessary link between the alleged obtaining of false CMNs and the submission of any claims for payment and thus has failed to identify any claims for payment predicated on the allegedly false CMNs. Simply put, Relator never alleges any facts with respect to the actual submission of false claims to the government.

Relator provides details such as patient initials and general dates with respect to allegations that Defendant Rotech re-rented capped equipment, billed Medicare for equipment no longer in use, and converted patients to motorized wheelchairs and alleges that Defendant Rotech billed the government for these services and for non-existent nursing home patients in Oklahoma. Compl. ¶¶ 128, 133, 164, 169. These averments arguably constitute allegations that specific claims were submitted; however, Relator wholly fails to allege any factual basis to support the allegations of the actual submission of claims. Relator, as a Rotech employee, may have acquired knowledge about Rotech's billing practices. However, Relator himself indicates that he was employed in a sales position and provides no factual support for his alleged knowledge of billing practices, much less for the specific claims which

he asserts were submitted to the government in the above-cited paragraphs. Indeed, Relator claims that he was a Rotech "insider" but fails to allege a factual basis for his claimed knowledge of Rotech's billing policies, other than that Rotech used CMNs in the provision of services and equipment. Rel.'s opp'n to Def. Rotech's Mot. Dismiss at 12. Relator has thus failed to provide the "indicia of reliability" required to satisfy Rule 9(b). *Clausen,* 290 F.3d at 1311; *U.S. ex rel. Carroll v. JFK Medical Center,* 2002 WL 31941007 (dismissing insider's False Claim Act suit for lack of specificity where allegations failed to provide facts, such as the costs of allegedly fraudulent procedures, to buttress the claims that defendants actually used fraudulent schemes to submit false claims).

Relator's argument that the information lacking here is exclusively held by Defendants so as to trigger a relaxed Rule 9(b) standard is unavailing. In *Clausen,* the Eleventh Circuit rejected such an argument, finding that the relator was not without avenues for obtaining the information and that in any case, the relator was not entitled to such leniency because he had not adequately alleged that the information was inaccessible nor plead any facts to support such allegation. *Id.* at 1314 n.25. Similarly, in this case Relator did not allege in the complaint that information with respect to the actual submission of claims to the government was within the exclusive control of Defendant.

Relator argues in the alternative that his allegation that Rotech created false documents is sufficient to state a claim under § 3729(a)(2) of the False Claims Act even in the absence of presentation of claims to the government. Relator relies on the holding in *BMY Combat Sys. Div. of Harsco Corp. v. U.S.,* as Fed. Cl. 109 (Fed. Cl. 1997), in which the United States Court of Federal Claims held that

actual delivery of false records is not necessary for a False Claims Act violation for false records to attach. However, that case is easily distinguishable from the instant facts: in *BMY Combat,* although the claimant did not actually give copies of the fraudulent documents to the government, the claimant induced the government's reliance by explicitly stating that the fraudulent forms existed as supporting documents for a proposition that the claimant knew to be false. *Id.* at 126. In this case, there is no allegation that Rotech ever made a specific, explicit representation to the government with respect to a fraudulent document.

However, Relator also argues that even if the Court finds that he has failed to state a cause of action under Rule 9(b) for violations of 31 U.S.C. §§ 3729(a)(1)-(2), his claim of retaliatory discharge is not subject to Rule 9(b) requirements and thus should not be dismissed. Relator alleges that he was terminated in retaliation for the filing of this suit in violation of 31 U.S.C. § 3730(h), which provides relief for employees who are terminated in retaliation for acts in relation to proceedings covered by the False Claims Act. An employee seeking relief under section 3730(h) must prove that he engaged in protected conduct and that the defendant retaliated against her because of that protected conduct. *Mann v. Olsten Certified Healthcare Corp.,* 49 F.Supp.2d 1307, 1313 (M.D.Ala. 1999).

In this case, Relator has alleged sufficient facts to establish that he was engaged in a protected activity when he was terminated. Specifically, Relator alleges that he brought this action while employed by Rotech and that when Rotech learned of the Relator's involvement, his employment was terminated. Compl. ¶¶ 180-82. These

allegations are sufficient to state a claim under section 3730(h). *See Hutchins v. Wilentz, Goldman & Spitzer,* 253 F.3d 176, 186 (3d Cir. 2001) (stating elements of retaliation claim as evidence that (1) the employee took acts in furtherance of a *qui tam* suit; (2) the employer knew of these acts; and (3) his employer discharged him as a result of these acts); *Zahodnick v. Int'l Bus. Machines, Corp.,* 135 F.3d 911, 914 (4th Cir. 1997) (same).[6]

Defendant Rotech argues that Relator cannot state a claim for retaliation in the absence of a viable claim of a substantive False Claims Act violation. However, the Eleventh Circuit has held that a relator need not actually file a complaint to state a claim of retaliation. *Childree v. UAP/GM CHEM. Inc.,* 92 F.3d 1140, 1146 (11th Cir. 1996). It follows that the retaliation protection does not depend on the success of the False Claims Act suit, as an actual suit is not required. Rather, retaliation protection is available not only when a suit is filed but also "where the filing of such an action, by either the employee or the government, was a 'distinct possibility' at the time the assistance was rendered." *Id.* Thus, a relator need not have a viable claim of fraudulent billing to state a cause of action but must only take action in furtherance of that claim and suffer adverse employment action as a consequence. *Cf. U.S. ex rel. Yesudian v. Howard Univ.,* 153 F.3d 731, 739-40 (D.C.Cir. 1998) (holding that the protected

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[6] Defendant Rotech contends that Relator never properly alleged that this *qui tam* action was the basis for the termination of Relator's employment and thus fails to adequately plead a retaliation claim. However, the Court finds that Relator's statement that Defendant Rotech fired him after discovering that he had filed a sealed *qui tam* action against the company is sufficient to support the claim that the *qui tam* action was the basis for his termination.

conduct element of a retaliation claim does not require the plaintiff to have developed a winning *qui tam* action before he is retaliated against); *U.S. ex rel. Satalich v. City of Los Angeles,* 160 F.Supp.2d 1092, 1108 (C.D.Cal. 2001) (holding that employee-whistleblower's retaliation claim was not dependent on his ability to succeed on, or even file, a cause of action under section 3729). Accordingly, Relator's retaliation claim may go forward despite the dismissal of the underlying False Claims Act allegations.

Because Relator's general allegations that the falsification of these documents led to the submission of false claims are insufficient to state a False Claims Act violation, Relator's specificity with respect to the falsification of the CMNs notwithstanding, Rotech's motion to dismiss is GRANTED with respect to Count I of the complaint. However, because Relator adequately pleaded a retaliation claim, Rotech's motion to dismiss is DENIED with respect to Count III of the complaint.

III. Relator's Motions for Relief from Judgement and to Amend the Complaint

Relator first seeks relief from the order dismissing the second amended complaint with regard to Defendants Lincare, Inc., Lincare Holdings Inc., American HomePatient, Inc. and Alan Varraux. Relator argues that since this Court issued that order, the Eleventh Circuit has clarified the law with respect to the specificity required of False Claim Act complaints and that the Court should therefore withdraw the order dismissing the other Defendants and allow Relator to amend the complaint a fourth time to satisfy the standard as stated in the *Clausen* opinion.

Because the complaint has not been dismissed with prejudice as to all Defendants, the order dismissing Lincare, American HomePatient, and Varraux is not final and thus may be revised at any time. F.R.C.P. 54(b) (noting that an order addressing fewer than all parties or claims is "subject to revision at any time"); *Bon Air Hotel, Inc. v. Time, Inc.*, 426 F.2d 858, 862 (5th Cir. 1970);[7] *Brodgen ex rel. Cline v. Nat'l Healthcare Corp.*, 103 F.Supp.2d 1322, 1338 (N.D.Ga. 2000). Reconsideration of an interlocutory decision is available under the standard, "as justice requires." Fed. R. Civ. P. 60 advisory committees note; *see also Canaday v. Household Servs., Inc.*, 119 F.Supp.2d 1258, 1260 (M.D.Ala. 2000) (holding that the trial court may reconsider or reverse its decision on an interlocutory order for any reason it deems sufficient). The Eleventh Circuits decision in *Clausen* does not constitute a circumstance mandating the relief Relator seeks with respect to the substantive False Claim Act violations. The decision did not change the law. Although the Eleventh Circuit issued the *Clausen* opinion in May, Relator did not attempt to amend the complaint until November. Further, Relator does not explain why he failed to allege the added detail of the proposed third amended complaint in any of the three previous complaints. Finally, the detail Relator seeks to add would not ameliorate the deficiencies which required the dismissal of second amended complaint. Relator simply fails to allege an adequate factual basis to

[7] This Court adopted as binding precedent all Fifth Circuit decisions prior to October 1, 1981. *Bonner v. City of Prichard*, 661 F.2d 1206, 1209 (11th Cir. 1981) (en banc).

support his assertions that fraudulent claims were submitted to the government.[8]

However, Relator also pleaded a retaliation claim against Defendant Lincare similar to the retaliation claim against Rotech. Compl. ¶¶ 197-200. The order dismissing the second amended complaint against Lincare did not specifically address Relator's retaliation claim. Because the Court finds that Relator sufficiently states a claim for retaliation against both Rotech and Lincare, the Court modifies its previous order pursuant to Rule 54(b) to allow Relator's retaliation claim against Lincare to proceed.

Finally, Relator seeks to amend the second amended complaint, purportedly to add the detail found lacking in that pleading. To date, Relator has had three opportunities to perfect his complaint. Additionally, this Court has previously advised Relator to comply with the requirements of Rule 9(b). *See U.S. ex rel. Corsello v. Lincare, Inc.*, No. 1:98-CV-0204-ODE, slip op. at 2 (N.D. Ga. June 18, 1999). Although "a plaintiff must be given at least one chance to amend the complaint before the district court dismisses the action with prejudice," the Court need not provide Relator with unlimited opportunities to correct his

[8] Relator argues in his motion to amend the complaint that he establishes a satisfactory indicia of reliability in the proposed third amended complaint by alleging that he cannot possibly identify billing detail because Defendant maintained its billing departments in remote locations. The Court does not see how this asserted complete lack of knowledge corroborates his claim. Further, although the allegation that the billing records are within Defendants' exclusive control suggests the application of a more lenient standard under Rule 9(b), Relator simply fails to allege adequate facts with respect to his employment at Rotech to support a relaxed specificity requirement.

complaint. *Bank v. Pitt,* 928 F.2d 1108, 1112 (11th Cir. 1991).

In determining whether to grant a motion to amend a pleading, the district court may consider such factors as "undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party by virtue of allowance of the amendment, [and] futility of amendment." *Foman v. Davis,* 371 U.S. 178, 182 (1962); *Nelson v. Doe,* 156 F.R.D. 583, 583 (N.D.Ga. 1995). As noted above, Relator waited over a year from the time the complaint was dismissed against the other defendants and six months from the issuance of the *Clausen* opinion to attempt to amend the complaint, has failed to adequately explain why he has failed to allege the added detail in any of the three previous complaints, and does not ameliorate with the proposed amendment the deficiencies which required that the second amended complaint be dismissed. Allowing Relator to amend the complaint at this point would certainly be inappropriate, given that Relator has unduly delayed the amendment and that an amendment would cause undue prejudice to the opposing party. *See* Fed. R. Civ. P 15(a). Accordingly, Relator's motion to amend the second amended complaint is denied.

IV. Conclusion

For the reasons stated above, Defendant Rotech's motion to dismiss is GRANTED with respect to Count I and DENIED with respect to Count III; Relator's motion for relief from the Court's order dismissing the second amended complaint with regard to Defendants Lincare,

Inc., Lincare Holdings Inc., American HomePatient, Inc. and Alan Varraux is GRANTED with respect to Count II as against the Lincare Defendants and DENIED as against the remaining Defendants; and Relators motion to amend the second amended complaint is DENIED.

SO ORDERED, this 30 day of MAY, 2003.

/s/ Orinda D. Evans
ORINDA D. EVANS
UNITED STATES
DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA ex rel. KIRK S. CORSELLO, and KIRK S. CORSELLO, Plaintiffs, v. LINCARE, INC.; LINCARE HOLDINGS INC.; AMERICAN HOMEPATIENT, INC.; ROTECH INC.; and ALAN VARRAUX, M.D.; Defendants.	CIVIL ACTION NO. 1:98-cv-0204-ODE

ORDER

(Filed Mar 9, 2001)

This *qui tam* civil action, filed pursuant to the False Claims Act, 31 U.S.C. § 3729 *et seq.*, is before the court on (1) American HomePatient, Inc.'s ("American HomePatient" or "Defendant") motion to dismiss Relator's second amended complaint for failure to comply with Federal Rule of Civil Procedure 9(b) and for failure to state a claim; (2) Lincare Inc. and Lincare Holdings Inc.'s ("Lincare" or "Defendant") renewed motion to dismiss pursuant to Federal Rules of Civil Procedure 9(b) and 12(b)(6); (3) Lincare's motion to dismiss qui tam claims on constitutional grounds; (4) Lincare's motion to file a supplemental brief in light of new authority; (5) Lincare's motion to dismiss pursuant to 31 U.S.C. § 3730(b)(5) and Federal Rule of Civil Procedure 12(b)(1); and (6) Lincare's motion for leave to file supplemental brief in light of *Clausen* decision. All motions are opposed by Relator Kirk S.

Corsello ("Relator") For the reasons set forth below, Defendants' motions to dismiss pursuant to Federal Rule of Civil Procedure 9(b) and 12(b)(6) are granted, Lincare's motion to file a supplemental brief in light of new authority and motion for leave to file supplemental brief in light of *Clausen* decision are granted nunc pro tunc, and Lincare's motion to dismiss qui tam claims on constitutional grounds and motion to dismiss pursuant to 31 U.S.C. § 3730(b)(5) and Federal Rule of Civil Procedure 12(b)(1) are dismissed as moot.

Relator brought this action on January 22, 1998 under the False Claims Act, 31 U.S.C. § 3729 *et seq.* He alleges that Defendants[1] engaged in Medicare fraud against the United States government through various fraudulent "schemes" designed to obtain Medicare payments unlawfully. Relator does not allege that he has been personally injured by Defendants' alleged actions, but only that the United States government has been harmed. The United States has not intervened in this case.

The complaint was unsealed and service was authorized on November 6, 1998. However, Relator failed to perfect service on any of the Defendants. On June 18, 1999, the court granted Relator's motion to file an amended complaint, but cautioned Relator as follows:

> The *Qui Tam* Act was not enacted in order to give the relator an unlimited opportunity to perfect its complaint or the government an unlimited opportunity to elect to intervene. However, in consideration of judicial economy and in light of

[1] Originally, Relator named fifty-six entities and ninety-nine John Does and John Doe Corporations as defendants.

> the fact that none of the parties to this action have yet been served, the court hereby GRANTS Plaintiff's motion for leave to amend the complaint. Plaintiff shall submit an amended complaint within ten (10) days of the entry of this order. *The amended complaint shall fully comport with the requirement of Fed.R.Civ.P. 9(b), which requires that fraud be plead with specificity.* "The plaintiff's complaint must allege the details of the defendant's allegedly frauduent acts, when they occurred, and who engaged in them." *Cooper v. Blue Cross and Blue Shield of Florida*, 19 F.3d 562, 568 (11th Cir. 1994). There will be no further extensions of time.

United States ex rel. Corsello v. Lincare. Inc., No. 1:98-CV-0204-ODE, slip op. at 2 (N.D. Ga. June 18, 1999) (emphasis added). Relator then served his first amended complaint on July 14, 1999 which, *inter alia*, amended the named defendants.

In an apparent attempt to cure some of the alleged deficiencies in his first amended complaint, Relator filed his second amended complaint on January 13, 2000, further reducing the number of named defendants. The remaining Defendants now include Lincare Inc., Lincare Holdings Inc.,[2] Rotech Medical Corporation ("Rotech" or "Defendant"),[3] American HomePatient, Inc., and Alan Varraux. Lincare Inc. and Lincare Holdings Inc. are nationwide providers of oxygen services and equipment to

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[2] In his pleadings, Relator refers to Lincare Inc. and Lincare Holdings, Inc. collectively as "Lincare." Because it is impossible to ascertain to which Lincare entity Relator refers, the court likewise will refer to both entities collectively.

[3] Rotech filed a notice of bankruptcy stay on February 25, 2000.

patients in their homes. Varraux is a physician specializing in pulmonology who allegedly had a medical director/consultant agreement with Lincare. American HomePatient is a nationwide supplier of durable medical equipment.

Relator states that he was employed by Lincare as a Center Manager for the South Orlando Center from August 15, 1995 through December 19, 1997. [Compl. at 2]. Additionally, according to Rotech, Relator obtained employment as a marketing representative for Rotech in Charleston, South Carolina from August, 1998 through November 4, 1998. [*See* Rotech's Mot. to Dismiss Amended Compl. at 4]. Based upon information allegedly obtained during his employment with Lincare and Rotech, Relator asserts that Defendants engaged in the following schemes resulting in violations of the False Claims Act.

Relator alleges that Defendants Lincare, Rotech, and American HomePatient provided illegal kickbacks to physicians to induce referrals of oxygen patients including cash payments, sporting events tickets, free patient services and tests, free or below market value equipment or medicine, and paid medical directorships.

With respect to Rotech and Lincare only, Relator alleges the existence of the following fraudulent schemes: 1) waiver of patients' twenty percent co-payment for oxygen services in the absence of any hardship to avoid patients' objections to overcharges or unnecessary equipment or medicine; (2) falsification, forgery, or illegal completion of certificates of medical necessity ("CMN") to enable the provision of unnecessary treatment and services; (3) improper testing and qualification of patients for certain services by falsifying diagnoses and/or test results,

manipulating tests to achieve a qualifying result, and qualification of patients by Defendants rather than an independent medical practitioner; (4) delivery of excess and unneeded unit dose medications; and (5) "trolling" for Medicare patients by reviewing physician files to identify patients who may be eligible for oxygen services.

Relator alleges that Rotech employed the following methods to defraud the Medicare system: (1) re-renting equipment which has already been fully paid for by Medicare (referred to as "capped" equipment); (2) billing Medicare for durable medical equipment (DME) no longer in use by the patient; (3) charging Medicare more than private insurance companies are charged for the same services; (4) converting Medicare patients to motorized wheelchairs, regardless of medical necessity, which can be billed at a higher rate; and (5) billing Medicare for nursing home patients in Oklahoma that did not exist.

Relator further alleges that Lincare relied on the following practices to submit improper claims for Medicare reimbursement: (1) "unbundling" prescriptions for respiratory medicines to enable Lincare to bill Medicare at a higher rate than that authorized when the medicines are prescribed together; and (2) billing for a full refill of oxygen regardless of the amount of oxygen needed to refill the patients' tanks.

In his second amended complaint, Relator asserts three counts of False Claims Act violations based on the aforementioned allegedly fraudulent schemes. In Count I, Relator alleges that all Defendants violated 31 U.S.C.

§ 3729(a)(1)[4] and (a)(2) by presenting false claims for payment and by submitting false records or statements for the purpose of payment of false claims. [*See* Compl. at 53-54]. Relator further alleges that Defendants Lincare and Varraux conspired to defraud the government by getting false claims allowed or paid in violation of 31 U.S.C. § 3729(a)(3). In Count II, Relator alleges that Defendant Lincare terminated him in violation of 31 U.S.C. § 3730(h).[5] [*See* Compl. at 54]. Count III is an identical retaliation claim against Defendant Rotech. [*See id.* at 55].

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[4] In relevant part, 31 U.S.C. § 3729(a) provides:

Any person who –

(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;

(2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;

(3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid; . . .

is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person. . . .

[5] In relevant part, that section provides:

Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee

(Continued on following page)

Lincare and American HomePatient each filed separate motions to dismiss pursuant to Federal Rules of Civil Procedure 9(b) and 12(b)(6). Additionally, Lincare has filed a motion to file a supplemental brief in light of new authority. Lincare has also filed, and American HomePatient has adopted, the following motions: (1) motion to dismiss qui tam claims on constitutional grounds; (2) motion to dismiss pursuant to 31 U.S.C. § 3730(b) and Federal Rule of Civil Procedure 12(b)(1); and (3) motion to file supplemental brief in light of *United States ex rel. Clausen v. Laboratory Corp. of America, Inc.*, No. 1:97-CV-2200 TWT, 2000 U.S. Dist. LEXIS 17162 (N.D. Ga. Nov. 29, 2000). The government has filed amicus briefs with respect to Defendants' motions to dismiss for failure to comply with Rule 9(b) and 12(b)(6) and on constitutional grounds. Varraux, proceeding *pro se*, has adopted Lincare's renewed motion to dismiss pursuant to Federal Rules of Civil Procedure 9(b) and 12(b)(6) and Lincare's motion to dismiss qui tam claims on constitutional grounds.

Turning first to Defendants' motions to dismiss pursuant to Federal Rules of Civil Procedure 9(b) and 12(b)(6), Defendants maintain that Relator's complaint is deficient in several respects. First, Lincare notes that because Relator refers to Lincare Inc. and Lincare Holdings Inc. collectively as "Lincare," both entities are deprived of proper notice of the allegations levied against

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would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate district court of the United States for the relief provided in this subsection.

them. [*See* Lincare's Renewed Mot. to Dismiss Pursuant to Fed.R.Civ.P. 9(b) and 12(b)(6) at 4]. Second, and most significantly, Lincare argues that Relator's "tainted claim theory" fails to sufficiently plead a violation of 31 U.S.C. § 3729(a)(1). Although Relator alleges generally,

> that 'every' claim for payment is 'false' if submitted after some impropriety has occurred, the [second amended complaint] does not identify one single false claim for payment that [Lincare] allegedly submitted to the government, let alone when, where or who submitted such a claim.

[*Id.* at 5]. Instead, the complaint sets forth, in varying degrees of detail, a wide range of Defendants' allegedly fraudulent or illegal practices. Absent allegations of the submission of specific false claims based upon Defendants' alleged misconduct, Lincare contends that Relator's complaint is fatally flawed.

Furthermore, Lincare maintains that the complaint fails to allege that Lincare submitted a false certification of compliance with federal regulations in violation of 31 U.S.C. § 3729(a)(2). Finally, Lincare submits that the complaint is devoid of any facts supporting Relator's conspiracy claim, such as the existence of an agreement between Defendants and Varraux to engage in fraud or evidence of an overt act taken pursuant thereto. [*Id.* at 8]. Having failed to adequately state a violation of the substantive provisions of the False Claims Act, Lincare avers that Relator's retaliatory discharge claim must fall as well. [*Id.* at 10]; *see* 31 U.S.C. § 3730(h).

In its motion to dismiss Relator's second amended complaint for failure to comply with Federal Rule of Civil Procedure 9(b) and for failure to state a claim, American

HomePatient offers similar arguments as to the deficiency of the complaint. Noting that American HomePatient is alleged to have been involved in only two of the numerous "schemes" outlined in the complaint, American HomePatient contends that Relator's allegations lack the factual specificity demanded by Rule 9(b). For example, Relator alleges that American HomePatient provided free medical equipment in exchange for physician referrals nationwide and throughout "the entire statutory time period." [American HomePatient's Mot. to Dismiss for Failure to Comply with Fed.R.Civ.P. 9(b) at 6]. Although the complaint does allege that such equipment was provided to Dr. Oscar Roadas in Jacksonville, Florida, American HomePatient maintains that such is insufficient for purposes of Rule 9(b). [*Id.* (citing *Rallis v. Holiday Inns, Inc.*, 622 F.Supp. 63, 65 (N.D. Ill. 1985))].

At the outset, Relator urges this court to modify existing law and hold the heightened pleading requirements of Rule 9(b) to be inapplicable to False Claims Act cases. However, in light of binding precedent from the United States Court of Appeals for the Eleventh Circuit holding that Rule 9(b) governs False Claims Act pleadings, the court declines to do so. *See Cooper v. Blue Cross & Blue Shield*, 19 F.3d 562, 566-67 (11th Cir. 1994). Notably, Relator cites no authority, binding or otherwise, to support his argument. *But see United States ex rel. Russell v. Epic Healthcare Management Group*, 193 F.3d 304, 308 (5th Cir. 1999) (noting that "[a] special relaxing of Rule 9(b) is a qui tam plaintiff's ticket to the discovery process that the statute itself does not contemplate); *United States ex rel. Clausen v. Laboratory Corp. of America, Inc.*, No. 1:97-CV-2200-TWT, 2000 U.S. Dist. LEXIS 17162, at *6 (N.D. Ga. Nov. 29, 2000) (rejecting Plaintiff's argument that Rule

9(b) should not apply to False Claims Act claims). Therefore, the court will apply the heightened pleading standards of Rule 9(b) to Relator's second amended complaint.

Relator maintains that even under the dictates of Rule 9(b), the second amended complaint passes muster. He contends that the complaint adequately sets out:

> the "who" – each scheme defines what Defendant(s) implemented it, and provides so much as possible the names of employees involved; the "what" – various specific types of misconduct, all of which culminated in false Certificates of Medical Necessity and resulting false claims for payment; the "where" – in most cases, nationwide, but with specific locations identified as to every Defendant with respect to every scheme; the "when" – in general, the entire period covered by the Act, but with specific periods (sometimes down to the date) identified by example; and the "how" – the essence of the schemes themselves.

[Relator's Mem. in Opp'n to the Mots. to Dismiss of Defendants Lincare, American HomePatient, and Alan Varraux at 11]. Essentially, Relator appears to argue that by providing sufficient detail regarding the methods by which Defendants allegedly submitted false claims for payment, he has met the requirements of Rule 9(b) for properly pleading a violation of the False Claims Act.

While the Federal Rules of Civil Procedure generally require in a complaint only a short and plain statement of the cause of action, Rule 9(b) states that "[i]n all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity. Malice, intent, knowledge, and other condition of a mind of a person may be averred generally." Fed.R.Civ.P. 9(b). In

addition to providing adequate notice to enable defendants to frame a response, this heightened standard serves to protect defendants from frivolous suits, to preclude fraud actions based upon facts obtained through discovery after the complaint is filed, and to prevent the damage to the goodwill and reputation of defendants that may result from even meritless claims. *United States ex rel. Stinson v. Blue Cross Blue Shield of Ga., Inc.*, 755 F.Supp. 1040, 1053 (S.D. Ga. 1990). Rule 9(b) may be satisfied if the complaint sets forth:

> (1) precisely what statements were made in what documents or oral representations or what omissions were made, and
>
> (2) the time and place of each such statement and the person responsible for making (or, in the case of omissions, not making) same, and
>
> (3) the content of such statements and the manner in which they misled the plaintiff, and
>
> (4) what the defendants "obtained as a consequence of the fraud.

Brooks v. Blue Cross and Blue Shield of Florida, Inc., 116 F.3d 1364, 1371 (11th Cir. 1997) (citations omitted). *See also Leonard v. Stuart-James Co.*, 742 F.Supp. 653, 659 (N.D. Ga. 1990) (motion to dismiss granted where complaint failed to allege "specifically when, where, by whom, or specifically what the representation was.").

Under certain circumstances, Rule 9(b) may be satisfied by alternative means. For example, where a complaint alleged generally that defendants engaged in racketeering activity by corresponding by mail, the submission of an affidavit demonstrating the existence of such correspondence was found to be sufficient. *Durham v. Business*

Management Assocs., 847 F.2d 1505, 1512 (11th Cir. 1988); *see also Seville Indus. Machinery Corp. v. Southmost Machinery Corp.*, 742 F.2d 786 (3d Cir. 1984) (complaint, containing general allegations of misrepresentations and accompanied by a list identifying with specificity the subject of the alleged fraud, was found to be sufficient). Alternatively, where the information needed to plead fraud is peculiarly in the possession of the defendant, a complaint may pass Rule 9(b) muster if it so alleges and contains "a statement of facts upon which the allegations are based." *United States ex rel. Stinson*, 755 F.Supp. at 1052.

The application of this standard recently resulted in the dismissal of a complaint containing allegations similar to those at bar. In *United States ex rel. Butler v. Magellan Health Servs., Inc.*, 101 F.Supp.2d 1365 (M.D. Fla. 2000), a former employee of one of the defendants alleged that defendants (1) submitted fraudulent claims to federal government agencies to obtain benefits and accreditation unlawfully; (2) presented false certification to those agencies to enhance benefits and meet state accreditations; and (3) encouraged unnecessary patient admissions by waiving Medicare deductibles and certain co-payments, and then submitting false claims derived from those admissions. *Id.* at 1367. After dismissing the first amended complaint without prejudice for failure to comply with Rule 9(b), the court analyzed the second amended complaint under the standard set forth by the Eleventh Circuit in *Brooks*. 116 F.3d at 1371. Although the plaintiff had included additional specific facts that expanded upon the general allegations in the first amended complaint, the court noted that:

> Plaintiff pleads generally and never references or produces any such documents which would support false claims to the government. Similarly, there are no time or place allegations relating to false claims. Additionally, Plaintiff has plead no facts relating to content of any false claims or the manner in which they were submitted. Finally, Plaintiff fails to plead what the defendants received specifically as a result of the alleged fraud. The most significant omission in the course of Plaintiff's false claim allegation is the absence of any documents or forms which Plaintiff claims contains some fraud.

United States ex rel. Butler, 101 F.Supp.2d at 1369. Because simply pleading the existence of a fraudulent scheme prohibited by law is insufficient for purposes of the False Claims Act, the court granted the motion to dismiss without leave to amend. *Id.* at 1370.

Applying this standard for pleading fraud with particularity, this court finds that Relator's second amended complaint falls short of compliance with the requirements of Rule 9(b). In his second amended complaint, Relator makes sweeping allegations with little factual specificity. Although some paragraphs of the complaint contain glimpses of the detail demanded by Rule 9(b), such is not sufficient to save an otherwise fact-starved complaint. The court will not analyze each paragraph of the fifty-six page complaint, but will instead cite representative examples of the complaints shortcomings.

Relator alleges that Lincare provided free equipment to "referring physicians all across the State of Florida and in all places where Lincare does business . . . during the entire statutory time period." [Compl. at 11, 31]. Although Relator cites three doctors in West Palm Beach, Florida

who allegedly received such equipment, this single example does not adequately support an allegation otherwise unlimited in time and geography.

Relators allegations with respect to Varraux are similarly deficient. Relator claims Varraux has had a "kickback relationship" with Lincare "since before 1990" involving the "unbundling" of medicines in exchange for "several thousand dollars per month" and "other kickbacks." [*Id.* at 15, ¶ 41]. Such vague assertions regarding the time period and the nature of the alleged fraud cannot survive the scrutiny of Rule 9(b).

The requisite factual detail is also lacking in the allegations regarding American HomePatient. Relator alleges that American HomePatient "entered into medical director agreements with referring physicians across the United States" consisting of monthly payments based on the number of patient referrals. [Compl. at 16, ¶ 45]. Relator again seeks to support this claim with a reference to two doctors in Jacksonville, Florida who allegedly received "approximately $750 per month for many years" pursuant to this referral scheme. [*Id.* at 17, ¶ 48]. Given the breadth of the allegation, this solitary detail is not adequate.

Most importantly, Relator never sufficiently alleges the submission of a false claim for payment to the government, the sine qua non of a False Claims Act violation. Although Relator asserts that Defendants' actions "resulted in the submission of thousands of false claims for payment to the United States," he fails to supply any further details as to when, where, and by whom any such claim was submitted to the government. [*See* Compl. at 19, ¶ 54]; *see also United States ex rel. Cox v. Iowa Health*

System, 29 F.Supp.2d 1022, 1025 (S.D. Iowa 1998) (dismissing False Claims Act count for failure to specify when and by whom each false claim was submitted for payment). Despite the weight of authority to the contrary, Relator seeks to frame his False Claims Act suit by generally alleging fraudulent practices which, in theory, could lead to the submission of false claims. This manner of pleading is not contemplated by the False Claims Act. *See United States ex rel. Clausen*, 2000 U.S. Dist LEXIS 17162, at *7 – 8; *accord U.S. ex rel. Schwartz v. Coastal Healthcare Group, Inc.*, No. 99-3105, 2000 WL 1595976 (10th Cir. 2000) (unpublished table decision) (plaintiff "describes only the generalities of how [the allegedly fraudulent scheme] operated, and nowhere does he identify a physician or a specific occasion when the practice resulted in a kickback or other illegal activity."); *U.S. ex rel. Walsh v. Eastman Kodak Co.*, 98 F.Supp.2d 141, 147-48 (D. Mass. 2000) ("Relater's First Amended Complaint, in essence, sets out a methodology by which the vendors might have produced false invoices, which in turn could have led to false claims. Without citing a single false claim arising from an allegedly false invoice, Relator has not met even a bare-bones Rule 9(b) test."); *Ex rel. G. Michael Gublo, et al v. Novacare, Inc.*, 62 F.Supp.2d 347, 354 (D. Mass. 1999) (dismissing complaint under Rule 9(b) where relator alleged three methods by which the defendant inflated its bills to the government, but failed to cite a single instance of a false claim); *United States ex rel. Sanders v. East Alabama Healthcare Authority*, 953 F.Supp. 1404, 1413 (M.D. Ala. 1996) ("While the Plaintiffs' First Amended Complaint alleges that [defendants] acted inappropriately during the CON procurement process, the court finds that the complaint does not tie these acts to the

submission of false claims or another activity prohibited by 31 U.S.C. § 3729(a).").

This court finds that the instant action is on all fours with *United States ex rel. Butler*, 101 F.Supp.2d at 1369. Just as the second amended complaint in *Butler* included "additional specific facts that expand upon the general allegations in the Amended Complaint," so too has Relator attempted to perfect his second amended complaint. *See id.* However, this court is likewise compelled to conclude that although "these allegations are illustrative of the type of fraud [Relator] alleges, none of these facts address any false claim or any document bearing a false claim on the part of Defendants." *See id.*

Relator's reliance on *United States ex rel. Johnson v. Shell Oil Co.*, 183 F.R.D. 204 (S.D. Tex. 1998) is unavailing. There, the plaintiff alleged that the defendants falsified monthly reports regarding oil sales and royalty remittances for land owned by the United States and leased by defendants, thereby underpaying their royalty obligations. *Id.* at 207. The plaintiff "set out in some detail seven schemes or methods defendants used to knowingly enter the false claims and underpay their royalty obligations." *Id.* Defendants argued that Rule 9(b) required the plaintiff to provide the specific dates and invoice numbers for each transaction and "the name of each employee who entered the alleged false information upon the [monthly report] for each lease, for each month for the last decade." *Id.* In denying the defendants, motion to dismiss, the court explained that the "particularities of this case do not compel such specifics since the what, when, and where are so obviously exactly plead." *Id.* Because the information sought by the defendants was solely a matter of internal

corporate affairs, the court held that Rule 9(b) did not command such a degree of detail. *Id.*

By contrast, the sparse details contained in the instant complaint do not adequately specify the what, when, and where of any allegedly fraudulent schemes. Moreover, Relator does not allege that the information lacking here is exclusively held by Defendants so as to trigger a relaxed Rule 9(b) standard. Unlike the complaint in *Johnson*, the instant complaint fails to sufficiently identify the conduct complained of such that Defendants could mount a defense. Permitting such a complaint to suffice would contravene one of the primary purposes of Rule 9(b): to notify defendants of the allegations against which they must defend. *Accord United States ex rel. Clausen*, 2000 U.S. Dist. LEXIS 17162, at *8.

Relator also relies on a selective quote from *Georgia Gulf Corp. v. Ward*, 701 F.Supp. 1556, 1560 (N.D. Ga. 1987), for his argument that Rule 9(b) does not require the inclusion of the dates and times of fraudulent conduct. [*See* Relator's Hem. in Opp'n to the Mots. To Dismiss of Defendants Lincare, American HomePatient, and Alan Varraux at 8]. However, the complete quote appears to support Defendants, position. In denying a motion to dismiss a RICO complaint for failure to comply with Rule 9(b), Judge O'Kelley explained:

> While Georgia Gulf has not alleged the exact dates when kickbacks were received, the complaint clearly shows who received them (Ward and Watkins), who paid them (Roskind and Holtrachem), and how they were paid (indirectly through Carolina Nitrogen, or directly by Roskind and Holtrachem), and how the mails and wires were used in furtherance of the

> scheme. Failure to state the dates and times of receipt of kickbacks is not fatal to the complaint, as the defendants have been apprised of the nature of the action against them, and are therefore on notice of sufficient allegations upon which to mount a defense.

Id. at 1560. Relator's complaint does not appear to contain the level of specificity described above. The isolated instances in which Relator specifies the date, location, persons involved, or method of fraudulent conduct do not sufficiently advise Defendants of the breadth of the charges against them.

To date, Relator has had three opportunities to perfect his complaint. Additionally, this court has previously advised Relator to comply with the requirements of Rule 9(b). *See United States ex rel. Corsello v. Lincare, Inc.*, No. 1:98-CV-0204-ODE, slip op. at 2 (N.D. Ga. June 18, 1999). Although "a plaintiff must be given at least one chance to amend the complaint before the district court dismisses the action with prejudice," the court need not provide Relator with unlimited opportunities to correct his complaint. *Bank v. Pitt*, 928 F.2d 1108, 1112 (11th Cir. 1991). Therefore, because Relator has failed to plead fraud with particularity as mandated by Federal Rule of Civil Procedure 9(b) and as previously directed by this court, the second amended complaint is dismissed with prejudice.

The court will now address Defendants' remaining motions. With respect to Lincare's motion to file a supplemental brief in light of new authority and motion for leave to file supplemental brief in light of *Clausen* decision, the court concludes that this authority is relevant to the resolution of the motion to dismiss, as discussed above. Thus, the court will exercise its discretion to grant said

motions nunc pro tunc. Lincare's remaining motion to dismiss qui tam claims on constitutional grounds and motion to dismiss pursuant to 31 U.S.C. § 3730(b)(5) and Federal Rule of Civil Procedure 12(b)(1) are dismissed as moot in light of the court's granting of Defendants' motion to dismiss pursuant to Federal Rule of Civil Procedure 9(b).

Accordingly, American Inc.'s motion to dismiss Relator's second amended complaint for failure to comply with Federal Rule of Civil Procedure 9(b) and for failure to state a claim [#115] is hereby GRANTED. Lincare Inc. and Lincare Holdings Inc.'s renewed motion to dismiss pursuant to Federal Rules of Civil Procedure 9(b) and 12(b)(6) (#116] is hereby GRANTED. Additionally, Lincare's motion to file a supplemental brief in light of new authority [#144] and Lincare's motion for leave to file supplemental brief in light of *Clausen* decision [#157] are hereby GRANTED NUNC PRO TUNC. Lincare's motion to dismiss qui tam claims on constitutional grounds [#117] and Lincare's motion to dismiss pursuant to 31 U.S.C. § 3730(b)(5) and Federal Rule of Civil Procedure 12(b)(1) [#152] are hereby DISMISSED AS MOOT.

SO ORDERED, this 9 day of MARCH, 2001.

/s/ Orinda D. Evans
ORINDA D. EVANS
UNITED STATES
DISTRICT JUDGE

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 05-11868-AA

KIRK S. CORSELLO,

Plaintiff-Appellant,

versus

LINCARE, INC.,
LINCARE HOLDINGS, INC.,
ROTECH, INC.,
ALAN VARRAUX, M.D.,
ROTECH MEDICAL CORPORATION,

Defendants-Appellees,

LINCARE HEALTHCARE
GROUP, INC., AMERICAN
HOME PATIENT, INC., et al.,

Defendants.

On Appeal from the United States District Court for the Northern District of Georgia

(Filed Jan 06, 2006)

BEFORE: TJOFLAT, DUBINA and PRYOR, Circuit Judges.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no member of this panel nor other Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5), the Petition(s) for Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

/s/ William H. Pryor, Jr.
UNITED STATES
CIRCUIT JUDGE

31 U.S.C. § 3729

§ 3729. False claims

(a) Liability for certain acts [Caution: For inflation-adjusted civil monetary penalties, see 28 CFR 85.3.]. Any person who –

(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;

(2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;

(3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;

(4) has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;

(5) authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(6) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or

(7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

is liable to the United States Government for a civil penalty of not less than $ 5,000 and not more than $ 10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person, except that if the court finds that –

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) such person fully cooperated with any Government investigation of such violation; and

(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation;

the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of the person. A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) Knowing and knowingly defined. For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information –

(1) has actual knowledge of the information;

(2) acts in deliberate ignorance of the truth or falsity of the information; or

(3) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.

(c) Claim defined. For purposes of this section, "claim" includes any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

(d) Exemption from disclosure. Any information furnished pursuant to subparagraphs (A) through (C) of subsection (a) shall be exempt from disclosure under section 552 of title 5.

(e) Exclusion. This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986.

31 U.S.C. § 3730

§ 3730. Civil actions for false claims

(a) Responsibilities of the Attorney General. The Attorney General diligently shall investigate a violation under section 3729 [31 USCS § 3729]. If the Attorney General finds that a person has violated or is violating section 3729 [31 USCS § 3729], the Attorney General may bring a civil action under this section against the person.

(b) Actions by private persons.

(1) A person may bring a civil action for a violation of section 3729 [31 USCS § 3729] for the person and for the United States Government. The action shall be brought in the name of the Government. The action may be dismissed only if the court and the Attorney General give written consent to the dismissal and their reasons for consenting.

(2) A copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the Government pursuant to Rule 4(d)(4) of the Federal Rules of Civil Procedure. The complaint shall be filed in camera, shall remain under seal for at least 60 days, and shall not be served on the defendant until the court so orders. The Government may elect to intervene and proceed with the action within 60 days after it receives both the complaint and the material evidence and information.

(3) The Government may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal under paragraph (2). Any such motions may be supported by affidavits or other submissions in camera. The defendant shall not be required to respond to any complaint filed under this section

until 20 days after the complaint is unsealed and served upon the defendant pursuant to Rule 4 of the Federal Rules of Civil Procedure.

(4) Before the expiration of the 60-day period or any extensions obtained under paragraph (3), the Government shall –

(A) proceed with the action, in which case the action shall be conducted by the Government; or

(B) notify the court that it declines to take over the action, in which case the person bringing the action shall have the right to conduct the action.

(5) When a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action.

(c) Rights of the parties to qui tam actions.

(1) If the Government proceeds with the action, it shall have the primary responsibility for prosecuting the action, and shall not be bound by an act of the person bringing the action. Such person shall have the right to continue as a party to the action, subject to the limitations set forth in paragraph (2).

(2) (A) The Government may dismiss the action notwithstanding the objections of the person initiating the action if the person has been notified by the Government of the filing of the motion and the court has provided the person with an opportunity for a hearing on the motion.

(B) The Government may settle the action with the defendant notwithstanding the objections of the person

initiating the action if the court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable under all the circumstances. Upon a showing of good cause, such hearing may be held in camera.

(C) Upon a showing by the Government that unrestricted participation during the course of the litigation by the person initiating the action would interfere with or unduly delay the Government's prosecution of the case, or would be repetitious, irrelevant, or for purposes of harassment, the court may, in its discretion, impose limitations on the person's participation, such as –

(i) limiting the number of witnesses the person may call;

(ii) limiting the length of the testimony of such witnesses;

(iii) limiting the person's cross-examination of witnesses; or

(iv) otherwise limiting the participation by the person in the litigation.

(D) Upon a showing by the defendant that unrestricted participation during the course of the litigation by the person initiating the action would be for purposes of harassment or would cause the defendant undue burden or unnecessary expense, the court may limit the participation by the person in the litigation.

(3) If the Government elects not to proceed with the action, the person who initiated the action shall have the right to conduct the action. If the Government so requests, it shall be served with copies of all pleadings filed in the action and shall be supplied with copies of all deposition transcripts (at the Government's expense). When a person

proceeds with the action, the court, without limiting the status and rights of the person initiating the action, may nevertheless permit the Government to intervene at a later date upon a showing of good cause.

(4) Whether or not the Government proceeds with the action, upon a showing by the Government that certain actions of discovery by the person initiating the action would interfere with the Government's investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay such discovery for a period of not more than 60 days. Such a showing shall be conducted in camera. The court may extend the 60-day period upon a further showing in camera that the Government has pursued the criminal or civil investigation or proceedings with reasonable diligence and any proposed discovery in the civil action will interfere with the ongoing criminal or civil investigation or proceedings.

(5) Notwithstanding subsection (b), the Government may elect to pursue its claim through any alternate remedy available to the Government, including any administrative proceeding to determine a civil money penalty. If any such alternate remedy is pursued in another proceeding, the person initiating the action shall have the same rights in such proceeding as such person would have had if the action had continued under this section. Any finding of fact or conclusion of law made in such other proceeding that has become final shall be conclusive on all parties to an action under this section. For purposes of the preceding sentence, a finding or conclusion is final if it has been finally determined on appeal to the appropriate court of the United States, if all time for filing such an appeal with respect to the finding or

conclusion has expired, or if the finding or conclusion is not subject to judicial review.

(d) Award to qui tam plaintiff.

(1) If the Government proceeds with an action brought by a person under subsection (b), such person shall, subject to the second sentence of this paragraph, receive at least 15 percent but not more than 25 percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the person substantially contributed to the prosecution of the action. Where the action is one which the court finds to be based primarily on disclosures of specific information (other than information provided by the person bringing the action) relating to allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government [General] Accounting Office report, hearing, audit, or investigation, or from the news media, the court may award such sums as it considers appropriate, but in no case more than 10 percent of the proceeds, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation. Any payment to a person under the first or second sentence of this paragraph shall be made from the proceeds. Any such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(2) If the Government does not proceed with an action under this section, the person bringing the action or settling the claim shall receive an amount which the court decides is reasonable for collecting the civil penalty and

damages. The amount shall be not less than 25 percent and not more than 30 percent of the proceeds of the action or settlement and shall be paid out of such proceeds. Such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(3) Whether or not the Government proceeds with the action, if the court finds that the action was brought by a person who planned and initiated the violation of section 3729 [31 USCS § 3729] upon which the action was brought, then the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action which the person would otherwise receive under paragraph (1) or (2) of this subsection, taking into account the role of that person in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the person bringing the action is convicted of criminal conduct arising from his or her role in the violation of section 3729 [31 USCS § 3729], that person shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. Such dismissal shall not prejudice the right of the United States to continue the action, represented by the Department of Justice.

(4) If the Government does not proceed with the action and the person bringing the action conducts the action, the court may award to the defendant its reasonable attorneys' fees and expenses if the defendant prevails in the action and the court finds that the claim of the person bringing the action was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.

(e) Certain actions barred.

(1) No court shall have jurisdiction over an action brought by a former or present member of the armed forces under subsection (b) of this section against a member of the armed forces arising out of such person's service in the armed forces.

(2) (A) No court shall have jurisdiction over an action brought under subsection (b) against a Member of Congress, a member of the judiciary, or a senior executive branch official if the action is based on evidence or information known to the Government when the action was brought.

(B) For purposes of this paragraph, "senior executive branch official" means any officer or employee listed in paragraphs (1) through (8) of section 101(f) of the Ethics in Government Act of 1978 (5 U.S.C. App.).

(3) In no event may a person bring an action under subsection (b) which is based upon allegations or transactions which are the subject of a civil suit or an administrative civil money penalty proceeding in which the Government is already a party.

(4) (A) No court shall have jurisdiction over an action under this section based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government [General] Accounting Office report, hearing, audit, or investigation, or from the news media, unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

(B) For purposes of this paragraph, "original source" means an individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the Government before filing an action under this section which is based on the information.

(f) Government not liable for certain expenses. The Government is not liable for expenses which a person incurs in bringing an action under this section.

(g) Fees and expenses to prevailing defendant. In civil actions brought under this section by the United States, the provisions of section 2412(d) of title 28 shall apply.

(h) Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate district court of the United States for the relief provided in this subsection.

Supreme Court, U.S.
FILED
JUN 09 2006
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(2)

No. 05-1288

In The Supreme Court of the United States

UNITED STATES OF AMERICA, *ex rel.* KIRK S. CORSELLO,

Petitioner,

v.

LINCARE INC., LINCARE HOLDINGS INC., LINCARE HEALTHCARE GROUP INC., AMERICAN HOMEPATIENT, INC., ROTECH, INC., ROTECH MEDICAL CORPORATION, and ALAN VARRAUX, M.D.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

RESPONSE TO PETITION FOR WRIT OF CERTIORARI

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RESPONSE TO PETITION FOR WRIT OF CERTIORARI

Respondents Lincare Inc. and Lincare Holdings Inc. (jointly referenced as "Lincare" or "Respondents"),[1] respectfully request that the Court deny Petitioner Kirk S. Corsello's ("Petitioner") petition for writ of certiorari.

INTRODUCTION

This case raises no issue of general importance and would resolve no split of authority among the federal circuit courts of appeal. Petitioner asks the Court to issue a writ of certiorari to review an uncontroversial Eleventh Circuit Court of Appeals' decision that simply applies well-settled law to the specific facts of this case.

In a non-argument decision issued on October 20, 2005, the Eleventh Circuit affirmed the District Court for the Northern District of Georgia's order: (1) dismissing Petitioner's Second Amended Complaint ("SAC") for failure to plead its broad False Claims Act[2] ("FCA") allegations with particularity pursuant to Fed. R. Civ. P. 9(b); and (2) denying Petitioner's request to file a belated Third Amended Complaint ("TAC") on the grounds that (a) Petitioner had been dilatory in filing the TAC and had repeatedly failed to cure deficiencies identified in prior amendments and (b) the TAC did not satisfy Rule 9(b) and, thus, amendment would have been futile.

Petitioner's representation that the SAC identified "dozens of examples of individual [false] claims submitted" by Respondents to the government for payment is inaccurate.[3] To the contrary, the SAC, much of which is based on

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[1] For purposes of simplicity, this brief will jointly refer to these defendants as "Lincare" and refer to the defendants separately as "Lincare Inc." and "Lincare Holdings Inc." when distinction is required.

[2] 31 U.S.C. § 3729 *et seq*.

[3] Pet. at 2.

"information and belief" speculation, does not identify a ***single*** specific false claim or a ***single*** particular payment by the government that was made on a purported false claim. Instead, Petitioner's SAC broadly alleges that "***every***" one of Respondents' claims for payment to the government for the last 15 to 20 years was false because Respondents purportedly engaged in a course of conduct throughout that period that violated ***other*** federal laws and regulations.

In an effort to brush over the history of his convoluted allegations, Petitioner fails to inform the Court that he has added, abandoned, and sometimes reinstated allegations, dropped and replaced defendants, dropped counts, expanded the temporal and geographic scope of his claims, violated the district court's orders, ignored the Northern District of Georgia's Local Rules, and burdened the record with numerous untimely or premature motions and appeals.

Furthermore, Petitioner's request also mischaracterizes the state of the law in the Eleventh Circuit regarding the application of Rule 9(b) to FCA complaints. Contrary to Petitioner's statements, the Eleventh Circuit employs the following flexible two-part disjunctive test to determine whether FCA complaints have been pleaded with particularity: whether the complaint identifies ***either*** specific claims that were actually submitted to the government ***or*** other facts sufficient to provide "some indicia of reliability" supporting the allegation that an actual false claim was made upon the government. This standard is not controversial, is consistent with similar authority in the other circuit courts of appeal, and has been frequently cited with approval by sister circuits. Moreover, Petitioner has profoundly exaggerated the limitations that the Eleventh Circuit's Rule 9(b) standard imposes on FCA cases. As evidenced by a recent Eleventh Circuit decision applying this standard, an employee with credible and specific information regarding false claims can successfully plead FCA claims without working in a defendant's billing department or specifically attaching a false claim to a complaint.

Finally, the two district court rulings underlying the Eleventh Circuit affirmance that Petitioner is asking the Court to review are supported by the law and justified by the unique facts of this case. Neither of these rulings implicate any important issues of general application and, thus, Petitioner cannot show that this case is worthy of consideration by the Court.

STATEMENT OF THE CASE

A. The Parties:

Lincare Inc. specializes in home respiratory care, providing oxygen services and equipment nationwide to patients in their homes, according to a physician's plan of treatment and prescription.[4] Petitioner managed a Lincare Inc. center for 2½ years before he was terminated more than 7 years ago, in late 1997.[5] Petitioner then sought and secured employment with Rotech Medical Corporation ("Rotech"), another company providing patients with home delivery of respiratory equipment and oxygen. Petitioner worked for Rotech from August 7, 1998 until November of 1998. Petitioner filed this action on January 22, 1998, just weeks after leaving Lincare Inc. and more than 7 months before Petitioner secured employment with Rotech.[6]

B. Proceedings At the District Court:

1. Petitioner's Inadequate And Inconsistent Complaints:

Since filing this case 8½ years ago as a sprawling *qui tam* action accusing 55 named defendants and another 99 "John Doe" defendants of violating the FCA, Petitioner has put forth a host of ever-changing allegations, dropping counts, replacing defendants, and expanding the temporal

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[4] Pet. App. at 32-33.

[5] *Id.*

[6] Res. App. at 1.

and geographic scope of his claims, which are summarized in the chart set forth below. Importantly, although these complaints made shifting claims regarding the dozens of defendants' alleged violations of various government regulations, none of Petitioner's complaints has ever identified a single specific false claim that was submitted to the government for payment. Because it is the submission of improper claims that gives rise to liability under the FCA, Petitioner's repeated failure to identify any such claims over several years and numerous complaints justifies both the district court's dismissal of his SAC for failure to satisfy Rule 9(b), and the Eleventh Circuit's affirmance of that dismissal.

PLEADING	DATE	DESCRIPTION
Original Complaint	01/22/98	• 154 Defendants (55 named defendants and 99 John Does)
First Amended Complaint ("FAC")	07/14/99	• 119 Defendants (drops 39 named defendants, adds 4 new named defendants, and keeps 99 John Does); • Drops Conspiracy Charge
Second Amended Complaint ("SAC")	01/13/00	• 5 Defendants (drops 15 out of 20 named defendants and 99 John Does) • Adds nationwide "information and belief" allegations • Reinstates conspiracy charge (dropped in the First Amended Complaint)
District Court Order	03/09/01	• Dismisses Petitioner's Second Amended Complaint in its entirety for failure to satisfy Rule 9(b)
First Motion for Reconsideration	10/18/02	• Requests reconsideration of 03/09/01 District Court Order
Proposed Third Amended Complaint ("TAC")	10/18/02	• Attached to Motion to Amend Second Amended Complaint (never became operative)
District Court Order	06/02/03	• Denies Petitioner's First Motion for Reconsideration, reinstates Petitioner's FCA employment retaliation claim

		and upholds 03/09/01 dismissal of substantive FCA claims
Fourth Amended Complaint	10/24/03	• Limits complaint to FCA employment retaliation claims (removes dismissed substantive FCA allegations in response to District Court's Order)
Fifth Amended Complaint	12/23/04	• Adds Rotech Medical Corporation as a named defendant
Second Motion for Reconsideration	02/24/05	• Requests Reconsideration of District Court's 03/09/01 and 06/02/03 Orders
District Court Order	06/21/05	• Denies Petitioner's Second Motion for Reconsideration

a. Petitioner's Original Complaint (55 Defendants):

Petitioner filed his Original Complaint in January of 1998.[7] This complaint made conclusory allegations that Lincare, Rotech, and over 150 other defendants – 53 other named parties[8] and 99 "John Does and John Doe Corporations" – had engaged in Medicare fraud through various vague schemes. These named defendants included numerous publicly-traded companies,[9] officers and employees of those

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[7] *Id.*

[8] Notably, the style of Petitioner's original complaint listed one corporate defendant, Lincare Healthcare Group, Inc., which did not exist, and one individual, Luis F. Baroroso, whom Petitioner completely failed to identify in "The Parties" section of the complaint. Res. App. at 1-2. To further the confusion, Petitioner subsequently lumped Baroroso in with 40 named defendants and 99 John Doe defendants in paragraph 71 of his complaint, which defines all the listed parties as "'Referring Physician' Defendants." The 55 named defendants referenced (which includes Lincare Inc. and Lincare Holdings Inc.) counts Lincare Healthcare Group, Inc. and Baroroso.

[9] Res. App. at 1 ¶¶ 7, 17, 20.

companies,[10] hospitals and medical centers,[11] at least two governmental entities,[12] and over two dozen doctors and other assorted medical practitioners.[13] Petitioner's Original Complaint completely failed to identify any purported false claims or specify the dates, locations, or nature of the alleged false claims.

After the United States declined to intervene in the case,[14] Petitioner elected to continue this litigation independently.[15] On November 6, 1998, the district court directed the Clerk to unseal Petitioner's Original Complaint and ordered service on the 55 named defendants. However, instead of serving the defendants, Petitioner belatedly sought leave to amend his Original Complaint. In granting the requested leave on June 18, 1999 and directing Petitioner to file his amended complaint within 10 days of its order, the district court expressly warned Petitioner about filing another vague complaint that did not satisfy Fed. R. Civ. P. 9(b), cautioning that:

> ***The Qui Tam Act was not enacted in order to give the relator an unlimited opportunity to perfect its complaint*** or the government an unlimited opportunity to elect to intervene.
>
> * * *
>
> ***The amended complaint shall fully comport with the requirement of Fed. R. Civ. P. 9(b), which requires that fraud be plead with specificity. "The plaintiff's complaint must allege the details of the defendants allegedly fraudulent acts, when they occurred, and who engaged in them."*** *Cooper v. Blue Cross & Blue*

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[10] *Id.* at ¶¶ 9-13.

[11] *Id.* at ¶¶ 21-22.

[12] *Id.* at ¶¶ 48-49.

[13] *Id.* at ¶¶ 26-32, 34-47, 50-54, 56-58.

[14] *See* 31 U.S.C. § 3730(b)(4)(B).

[15] *Id.*

Shield of Florida, 19 F.3d 562, 568 (11th Cir. 1994).[16]

b. Petitioner's First Amended Complaint (Dropping 70% Of The Named Defendants, Adding New Defendants, And Changing Geographic Focus):

Petitioner failed to file his First Amended Complaint within the district court's 10-day deadline, despite the district court's clear admonition that "[t]here will be ***no further extensions of time***."[17] Demonstrating considerable restraint and patience, the district court nevertheless granted Petitioner another extension of time *nunc pro tunc* on August 25, 1999. Petitioner finally served Lincare with his First Amended Complaint, almost 9 months after the district court originally ordered the complaint unsealed and served.

Petitioner's allegations changed dramatically between his Original Complaint and the First Amended Complaint. While retaining the Original Complaint's inscrutably vague character, the First Amended Complaint: (1) eliminated 39 of the 55 defendants named in the Original Complaint;[18] (2) sought to add 4 new defendants without requesting leave of court;[19] (3) dropped the conspiracy count from the Original Complaint, and (4) for the first time, focused on conduct and employees in Lincare facilities in central and south Florida

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[16] Res. App. at 25.

[17] *Id.* (emphasis added).

[18] Res. App. at 28. Petitioner's Amended Complaint dropped 11 private entities, 2 governmental entities, 1 office manager, and 25 medical professionals.

[19] *Id.* ¶¶ 10, 13-14, 17 (adding four named defendants). Notably, while Fed. R. Civ. P. 21 states that "Parties may be dropped or added ***by order of the court*** on motion of any party," (emphasis added), Petitioner did not seek leave from the district court to add these parties.

(primarily in the Orlando area, where Petitioner had managed a Lincare Inc. center).[20]

On August 23, 1999, the defendants moved to dismiss Petitioner's First Amended Complaint for failure to: (1) plead fraud with particularity under Rule 9(b), and (2) state a claim under Rule 12(b)(6) and the FCA. Petitioner responded by moving for leave to amend his Second Amended Complaint on October 7, 1999 (while the defendants' motions to dismiss were pending) in what the district court called "an apparent attempt to cure some of the alleged deficiencies in his first amended complaint."[21] In January of 2000, the district court granted Petitioner's leave to file a SAC, which he filed on January 13, 2000.

c. Petitioner's SAC (Dropping Another 75% Of The Named Defendants And Radically Expanding The Scope of The FCA Allegations Against Respondent Lincare):

Petitioner's SAC radically altered the nature of his FCA allegations. While remaining as vague and conclusory as its predecessors, Petitioner's SAC again dramatically reduced the number of named defendants, eliminating 15 of the 20 that appeared in his First Amended Complaint and dropping all claims against the 99 "John Does and John Doe Corporations." Thus, the SAC left only 5 named defendants (*i.e.*, Rotech, American HomePatient, Inc., Lincare Inc., Lincare Holdings Inc., and Dr. Alan Varraux, M.D.). Therefore, by the time that the SAC was filed, Petitioner had abandoned his claims against 51 of 55 named defendants and all 99 "John Doe" defendants. No "John Doe" defendant was ever identified. Having dropped numerous defendants,

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[20] Res. App. at 28. Regarding Lincare's conduct, Petitioner's First Amended Complaint listed: (1) West Palm Beach, Florida, ¶¶ 68-69, 77; (2) Altamonte Springs, Florida, ¶ 77; (3) Vero Beach, Florida, ¶ 77; (4) Ochecobee [sic], Florida, ¶ 77; (5) Lakeland, Florida, ¶ 84; and (7) Tampa, Florida, ¶ 96. Notably, Petitioner's Original Complaint mentioned no locations where any of the alleged misconduct occurred.

[21] Res. App. at 135.

however, the SAC then inexplicably reasserted the conspiracy claim that had appeared in his Original Complaint but was deleted from his First Amended Complaint and radically enlarged the scope of Petitioner's allegations against Lincare in terms of both time and geography. Even though Petitioner only worked for Lincare in one central Florida center for 2½ years,[22] his SAC alleged that Lincare submitted false claims (1) in ***every state*** in which it does business[23] (2) for ***at least a dozen years***.[24] Pointedly ignoring the district court's admonition regarding Rule 9(b), Petitioner based more than 60 of his SAC's fraud allegations on no more than "information and belief" speculation.[25] As the district court later observed, the SAC makes "sweeping allegations,"[26] which are "unlimited in time and geography"[27] and provide "little factual specificity."[28]

2. District Court's Orders Dismissing Petitioner's SAC:

a. March 9, 2001 Order:

Respondents renewed their motions to dismiss under Rules 9(b) and 12(b)(6) in February, 2000, and, on March 9, 2001, the district court granted the motions and dismissed the SAC with prejudice. In doing so, the court wrote a detailed 20-page decision that examined the SAC's numerous deficiencies.[29] Holding that Petitioner's SAC fell "short of

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[22] Res. App. at 69.

[23] *Id.* ¶¶ 26, 29(a), 29(b), 31, 33, 51, 142, 153, 159.

[24] *Id.* ¶¶ 26, 32, 38, 51 (alleged conduct occurred throughout the "late 1980's and 1990's."); ¶ 86 ("[f]rom before 1984 through 1997 and, upon belief, to the present"); ¶ 111 ("[t]hroughout the 1990s").

[25] *Id.* ¶¶ 25-29(a), 29(c), 31-32, 34, 38, 47, 50-51, 56-57, 60-61, 64, 66-67, 69, 72, 76-77, 81, 84, 86, 89, 94, 96, 103-108, 112-113, 118, 118(c), 120, 122, 129, 134, 139, 142-143, 153, 159-160, 162, 165, and 169.

[26] Res. App. at 145

[27] *Id.* at 146.

[28] *Id.* at 145.

[29] Pet. App. at 30-48.

compliance with the requirements of Rule 9(b)," the court explained that "the sparse details contained in the [SAC did] not adequately specify the what, when, and where of any allegedly fraudulent schemes," or "sufficiently advise Defendants of the breadth of the charges against them."[30]

The district court dismissed Petitioner's SAC with prejudice because, by March of 2001, Petitioner had failed in "three opportunities to perfect his complaint,"[31] two of which were provided ***after*** the district court's June 18, 1999 express warning that Petitioner would not be given an "unlimited opportunit[y] to perfect [its] complaint" and any amendment would have to "fully comport with the requirement of Fed. R. Civ. P. 9(b), which requires that fraud be plead with specificity."[32]

b. June 2, 2003 Order:

Following the dismissal of Petitioner's premature appeal of the district court's March, 2001 Order,[33] Petitioner moved for reconsideration on October 18, 2002, asking the district court to either: (1) reconsider its March 9, 2001 dismissal of his SAC against all the defendants or (2) allow him to amend his SAC by filing the proposed TAC. In an order entered on June 2, 2003, the district court:

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[30] Rep. App. at 144-145, 148-150.

[31] *Id.* at 150-151

[32] Res. App. at 24-25.

[33] Because Rotech had filed for bankruptcy protection in February of 2000, resulting in an automatic stay of Petitioner's claims against Rotech at that time, the district court's order did not dismiss the SAC as to Rotech, and, thus, the dismissal was not an appealable final order under 28 U.S.C. § 1291. The Eleventh Circuit Court of Appeals dismissed Petitioner's appeal for want of jurisdiction in December of 2001. *Corsello v. Lincare, Inc.*, 276 F.3d 1229 (11th Cir. 2001).

(1) denied Petitioner's motion for reconsideration[34] because:

(a) it was untimely (being filed more than 19 months after the initial dismissal of his SAC and 5 months after the Petitioner's premature appeal was remanded) and

(b) Petitioner's SAC failed to satisfy Rule 9(b) because it "fail[ed] to make the necessary link between the alleged obtaining of false CMNs [Certificates of Medical Necessity, a physician's attestation that the durable medical prescribed is necessary] and the submission of any claims for payment and thus has failed to identify any claims for payment predicated on the allegedly false CMNs;"[35]

(2) denied Petitioner's motion to amend his SAC because:

(a) the motion to amend was untimely,

(b) Petitioner failed to explain why he could not have included his TAC's new allegations in any of his 3 previous complaints, and

(c) "the detail Relator seeks to add would not ameliorate the deficiencies which required the dismissal" of his SAC.[36]

c. June 21, 2005 Order:

On February 24, 2005, ***more than 20 months after the district court's June 2, 2003 denial of Petitioner's first motion for reconsideration***, Petitioner filed another motion for reconsideration. As the district court later noted,

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[34] The district court granted Petitioner's motion for reconsideration of its dismissal of his FCA retaliation claims because these claims did not have to be pleaded with particularity. However, Petitioner voluntarily dismissed these claims on March 4, 2005.

[35] Pet. App. at 21.

[36] Res. App. at 166.

this was Petitioner's "***third attempt*** to litigate the issue of whether the claims in his Second Amended Complaint are adequately pleaded."[37]

On June 21, 2005, the district court denied Petitioner's second motion for reconsideration on the grounds that it: (1) "blatant[ly] disregard[ed] [] this Court's local rules,"[38] which prohibit "motions to reconsider the court's denial of a prior motion for reconsideration;"[39] (2) was "indefensibly late" – being filed "almost four years after the March 9, 2001 Order dismissing" Petitioner's SAC "and over 20 months after [the district court's] June 2, 2003" denial of Petitioner's First Motion to Reconsider[40] – and (3) was "entirely without merit."[41]

REASONS FOR DENYING PETITION

A. THE LEGAL STANDARD: This Case Does Not Raise Any Important Legal Issues Regarding Rule 9(b)'s Application To FCA Complaints.

1. Rule 9(b) Applies To This FCA Case.

Petitioner's request for certiorari argues that Rule 9(b) should not apply to his FCA complaint because Rule 9(b) only applies to "averments of fraud" and the FCA does not require proof of fraud in all cases.[42]

While Respondents strongly dispute the soundness of Petitioner's assumption that Rule 9(b) does not apply to all FCA claims,[43] ***Petitioner fails to mention that his FCA claims clearly sound in fraud.***

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[37] Res. App. at 173-175 (emphasis added).

[38] *Id.*

[39] *Id.* (quoting Local Rule 7.2E).

[40] *Id.*

[41] *Id.*

[42] Pet. at 11, 24-30.

[43] *See generally Juliano v. Federal Asset Disposition Ass'n*, 736 F. Supp. 348, 353 (D.D.C. 1990), *aff'd*, 959 F.2d 1101 (D.C. Cir. 1992) (holding that elimination in 1986 of the specific intent requirement did not

(Continued on following page)

Petitioner has asserted fraud theories throughout the pendency of this action using words like "fraud" with greater frequency in each successive complaint. Petitioner's Original Complaint and First Amended Complaint clearly sound in fraud, referencing "fraud," "defraud," "fraudulent," or "Medicare fraud" at least 13[44] and 20[45] times, respectively. Indeed, Petitioner titled Count II of his Original Complaint "CONSPIRACY TO ***DEFRAUD*** THE UNITED STATES,"[46] conclusively establishing from the outset of this case that his FCA claims sound in fraud. Moreover, the SAC uses the terms "fraud," "defraud," "fraudulent," and "Medicare fraud" at least 24 separate times.[47]

The following allegations in the SAC are emblematic of Petitioner's broad fraud-based claims against Respondents: (1) that Petitioner "became aware of specific ***fraudulent*** acts and schemes perpetrated by Lincare,"[48] (2) that Petitioner "also learned facts indicating that other suppliers of durable medical equipment engaged in the same ***fraudulent*** practices,"[49] (3) that Petitioner "continued to investigate and acquire evidence of Medicare ***fraud*** within Lincare during his employment,"[50] (4) that "Defendants Lincare and Varraux conspired to ***defraud*** the Government by getting false claims allowed or paid,"[51] and (5) that "[t]he United States is entitled to [a] sum as reimbursement for monies obtained by

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do away with the requirement that the false claim had to be pleaded with particularity).

[44] Res. App. at 1 ¶¶ 60, 72, 86, 93, 94, 95 (three), 99, 105 (twice), 108 and subheading of Count II.

[45] Res. App. at 28 ¶¶ 38, 52 (twice), 59, 60, 61 (three times), 79, 80 (five times), 74, 85, 105, 106, 108.

[46] Res. App. at 20-21 (emphasis added).

[47] Res. App. at 69 ¶¶ 23 (twice), 49 (three times), 52 (twice), 104a (twice), 115 (once), 171 (once), 172 (once), 173 (twice), 174 (once), 175 (once), 176 (once), and 177 (twice), 179 (once), 190 (once), 192 (once), 193 (once), 195 (once).

[48] *Id.* ¶ 171 (emphasis added).

[49] *Id.* ¶ 172 (emphasis added).

[50] *Id.* ¶ 176 (emphasis added).

[51] *Id.* ¶ 192 (emphasis added).

the Defendants for ***fraudulent*** claims submitted to the United States."[52] Because Petitioner's action clearly alleges that Respondents committed ***fraud***, any question regarding whether Rule 9(b)'s heightened pleading requirements would apply to a hypothetical non-fraud based FCA claim is mere conjecture, unmoored to the record in this case.[53]

2. The Eleventh Circuit's Application Of Rule 9(b) Is Not Unduly Restrictive And Is Not A Roadblock To Legitimate FCA Actions.

a. Petitioner Mischaracterizes The Eleventh Circuit's Rule 9(b) Standard In FCA Cases.

Petitioner mischaracterizes the Eleventh Circuit's legal standard for applying Rule 9(b) in FCA cases. Petitioner's brief repeatedly implies that the Eleventh Circuit requires an FCA relator to identify ***both*** actual false claims that were submitted by a defendant to the government for payment ***and*** facts providing some indicia of reliability that actual false claims were made to the government.[54] This is not the law in the Eleventh Circuit.

As delineated in *United States ex rel. Clausen v. Laboratory Corp. of America*, 290 F.3d 1301 (11th Cir. 2002), an FCA complaint satisfies Rule 9(b) by identifying ***either*** specific claims that were actually submitted ***or*** other facts sufficient to provide "some indicia of reliability" supporting the allegation that an actual false claim was made upon the government.[55] Thus, *Clausen* established a flexible disjunctive standard by which FCA claims are analyzed, allowing *qui tam* complaints to proceed even if they do not identify specific claims that were actually submitted so long as they contain a sufficient modicum of specific facts to reliably show

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[52] *Id.* ¶ 193 (emphasis added).

[53] *See, e.g.*, *Clinton v. Jones*, 520 U.S. 681, 690 n. 11 (1997).

[54] *See, e.g.*, Pet. at 3 (stating that the "indicia of reliability" showing was "necessary to support an allegation that claims had been submitted").

[55] 290 F.3d 1301, 1311 (11th Cir. 2002).

that the defendant presented a false claim to the government for payment. *Clausen* merely holds that, because the FCA does not create liability for a defendant's mere regulatory violations or improper policies, a complaint must sufficiently allege the presentation of a false claim to the government with particularity and not merely infer from allegations of generalized misconduct that resulting false claims were submitted.

The *Clausen* standard is neither controversial nor inconsistent with similar authority in the other circuit courts of appeal. In fact, *Clausen* has been frequently cited with approval by sister circuits. For instance, in *Sanderson v. HCA-The Healthcare Co.*, ___ F.3d ___, 2006 WL 1302479 (6th Cir. May 12, 2006), the Sixth Circuit recently applied the *Clausen* standard in upholding a district court's dismissal or an FCA complaint that is similar to Petitioner's SAC in this case. In *Sanderson*, the complaint merely alleged that the defendant employed a purportedly improper accounting practice involving allocation of corporate debt and then concluded that any claims to the government for reimbursement of debt expenses resulting from the accounting method were necessarily false. While the *Sanderson* complaint referenced a few specific loans on which the defendant allegedly applied the improper accounting method and the dates on which the notes and debentures securing those loans came due, it did not contain any specific information about the filing of claims with the government and, thus, did not put the defendants on notice of the precise misconduct (*i.e.*, the submissions of specific false claims) at issue.

Likewise, the Eighth Circuit also recently applied the *Clausen* standard in *United States ex rel. Joshi v. St. Luke's Hosp., Inc.*, 441 F.3d 552 (8th Cir. 2006), a decision upholding a district court's dismissal of an FCA complaint that was also materially similar to Petitioner's SAC in this action. Filed by anesthesiologists, the *Joshi* complaint alleged that every claim to the government from a hospital for nurse anesthetist work was fraudulent because the nurses were not

properly supervised pursuant to applicable Medicare regulations.[56] The *Joshi* court held that the plaintiff both failed to identify any false claims or otherwise provide facts sufficient to reliably assert that specific false claims were submitted for payment to the government. In particular, the court noted that the complaint did not provide enough specific times, places, actors, and actions to forge a reliable specific link between the alleged misconduct and a purported particular false claim.

Petitioner has also profoundly exaggerated the limitations that the Eleventh Circuit's Rule 9(b) standard imposes on FCA cases. Petitioner's assertion that the "Eleventh Circuit has effectively held that only those persons working in a defendant's billing department can properly allege that claims for payment had been submitted to the government" is belied by the Eleventh Circuit's recent decision in *United States ex rel. Walker v. R&F Properties of Lake County, Inc.*, 433 F.3d 1349 (11th Cir. 2005).[57] In this case, the court of appeals held that the *Clausen* standard was satisfied in a Medicare-related FCA action brought by a nurse who did not work in the defendant's claims department.[58] The court found that, while the relator failed to identify specific false claims submitted to the government for payment, the complaint did provide an adequate indicia of reliability by specifically explaining the unlawful billing and record keeping practices in which the defendant was engaging and reliably stating with supporting facts that defendant "never" deviated from those fraudulent billing practices.[59]

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[56] 441 F.3d 552, 554 (8th Cir. Mar. 6, 2006).

[57] 433 F.3d 1349, 1360 (11th Cir. 2005).

[58] *Id.*

[59] *Id.* (distinguishing the facts of *R&F* from the *Corsello* decision).

b. The Eleventh Circuit's Application Of Rule 9(b) Will Not Deter FCA Relators From Bringing Legitimate Actions Or Undermine The Effectiveness Of The Act.

Petitioner argues that the Court should grant certiorari in this case because the Eleventh Circuit's application of Rule 9(b) to his SAC (1) "seriously undermine[s] this Congressional policy" underlying the enactment of the current FCA statute of "induc[ing] persons with knowledge of fraud to come forward and file *qui tam* actions"[60] and (2) "greatly undermine[s] the effectiveness of the False Claims Act as a tool for combating fraud."[61] Petitioner's policy argument fails because it ignores the following key facts. Initially, all FCA cases are filed under seal for a period of time sufficient to allow the government to investigate the claims, serve administrative subpoenas, and obtain any particular information that is necessary to amend a relator's potentially vague complaint if it is warranted.[62] As such, Rule 9(b) does not protect culpable defendants because the government can, and does, discover detailed claims information before the defendant is even served with the original complaint, and the government has the opportunity to amend the complaint as a matter of right at that time. In addition, all relators have an opportunity to independently investigate their claims before filing the action. For an employee of a prospective defendant, identifying information concerning the actual submission of false claims (*e.g.*, amounts of claims, false statements, authors of statements, and dates of claim transmissions) is not an impossible task. Indeed, considering the significant expense and serious reputational harm that FCA actions can impose on defendants, requiring prospective relators to investigate these details before filing a case and to plead with particularity when a case is filed is an important

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[60] Pet. at 19

[61] Pet. at 23.

[62] Notably, Lincare responded to a government subpoena relating to Petitioner's allegations in 1999.

safeguard against premature claims based on little more than potential regulatory violations and hypothetical assumptions that related false claims could have been filed.

This case is a stellar example of how a reckless relator can burden the courts and impose expenses upon defendants in his search for an FCA bounty.[63] Nowhere in 8½ years worth of pleadings has he undertaken to explain the reckless fashion in which he has sued over 50 individuals and entities without any apparent basis or in which he has alleged, dropped, and realleged claims and sought reconsideration of years-old rulings. Contrary to Petitioner's apparent belief, the FCA exists for the benefit of the government, not relators, and neither the government nor the public are served by the convulsive allegations seen in this case.

B. APPLICATION TO THIS CASE: This Case Is A Routine Dismissal That Is Not Worthy Of Issuance Of A Writ Of Certiorari.

Petitioner is requesting the Court to issue a writ of certiorari and review the Eleventh Circuit's affirmance of two unremarkable rulings by the district court. In particular, the district court (1) denied Petitioner's SAC for failure to plead his FCA claims with particularity after filing three deficient and materially inconsistent complaints and (2) denied Petitioner's untimely motion to amend his SAC and file a TAC. Both of these rulings are supported by the law and justified by the facts of this case. Both of these rulings were made with respect to the unique facts of this case and neither implicates any important issue of general application. As such, Petitioner cannot show that this case is worthy of consideration by the Court on certiorari.

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[63] Notably, Petitioner's overbroad and indefinite claims suggest an intention to serve equally expansive and burdensome discovery requests and use his vague claims "as a pretext to uncover unknown wrongs." *U.S. ex rel. Robinson v. Northrop Corp.*, 149 F.R.D. 142, 144 (N.D. Ill. 1993). Proceeding with such discovery would impose substantial business disruption and litigation expenses on the defendants and unnecessarily consume scarce judicial resources in settling inevitable discovery disputes.

1. Petitioner's SAC Fails To Provide Any Of The Specifics Necessary To Satisfy Rule 9(b).

"'At a minimum, [Rule 9(b)] requires that a [FCA] plaintiff set forth the "***who***, ***what***, ***when***, ***where***, and ***how***" of the alleged fraud.'"[64] These are "the . . . bare facts" of an FCA claim – "the first paragraph of any newspaper story.'"[65]

a. BALD SPECULATION: The SAC Is Founded On Mere "Information And Belief."

Having been admonished by the district court to provide specificity, the Petitioner responded with prolixity. Petitioner's SAC bases more than 60 of its allegations on mere "information and belief" guesswork.[66] These vague and speculative allegations infect every area of the SAC: physician kickbacks,[67] provision of sporting tickets to referral sources,[68] improper completion of CMNs,[69] and improper patient testing.[70] Importantly, some of these paragraphs even include those in which Petitioner purports to provide "specific examples" of the vaguely alleged misconduct.[71]

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[64] *United States ex rel. Williams v. Bell Helicopter Textron Inc.*, No. 04-10468, 2005 WL 1632266, at *2 (5th Cir. July 13, 2005) (emphasis added) (quoting *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 125 F.3d 899, 903 (5th Cir. 1997)).

[65] *Hemenway v. Peabody Coal Co.*, 159 F.3d 255, 261 (7th Cir. 1998) (quoting *DiLeo v. Ernst & Young*, 901 F.2d 624, 627 (7th Cir. 1990)).

[66] Res. App. at 69 ¶¶ 25-29(a), 29(c), 31-32, 34, 38, 47, 50-51, 56-57, 60-61, 64, 66-67, 69, 72, 76-77, 81, 84, 86, 89, 94, 96, 103-108, 112-113, 118, 118(c), 120, 122, 129, 134, 139, 142-143, 153, 159-160, 162, 165, and 169.

[67] *Id.* ¶ 25.

[68] *Id.* ¶¶ 27-28.

[69] *Id.* ¶¶ 56-57, 60, 62, 66, 76-77, 81, 89, 94, 96.

[70] *Id.* ¶¶ 105-108, 112-113, 118, 120.

[71] *Id.* ¶¶ 76 (founding allegations of "[s]pecific examples" of improperly completed CMNs relating to Lincare on "information and belief"); 81 (founding allegations of "[s]pecific examples" of improperly completed CMNs relating to Rotech on "information and belief"); 106 (founding allegations of "[s]pecific examples" of improper medical testing on "information and belief").

A *qui tam* relator may not plead factual allegations of fraud "upon information and belief" unless the relator can: (1) specifically allege that the necessary information lies within the defendant's control and (2) includes a statement of the facts upon which the relator's information and belief is based.[72] The SAC does neither of these.

First, Petitioner's SAC does not allege that any of the necessary facts are exclusively within Respondents' control. Indeed, given the fact that the SAC alleges that Lincare (1) filed thousands of false claims with the government,[73] (2) canceled kickback relationships with doctors who failed to refer enough patients to Lincare,[74] (3) improperly induced patients to receive government funded oxygen by waiving their co-payments,[75] (4) performed oxygen qualification testing on patients,[76] and (5) encouraged third-party physicians to sign blank prescription forms without inquiry,[77] there should be extensive evidence of Lincare's allegedly fraudulent activities outside the company's exclusive control (*e.g.*, in patients' personal Medicare billing records as well as the files of Lincare's Medicare fiscal intermediaries, the government, and referring physicians). While Petitioner may not have had access to these documents, they were not exclusively in Lincare's control and were available to a number of other parties who could have brought their own FCA actions on behalf of the government if the documents evidenced false claims. The FCA was drafted to encourage those with specific knowledge of false claims to come forward, not to promote opportunistic suits by those, like

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[72] *See, e.g.*, *United States ex rel. Karvelas v. Melrose-Wakefield Hosp.*, 360 F.3d 220 (1st Cir. 2004); *United States ex rel. Willard v. Humana Health Plan of Texas Inc.*, 336 F.3d 375 (5th Cir. 2003).

[73] Res. App. at 69 ¶¶ 54, 154.

[74] *Id.* ¶ 40.

[75] *Id.* ¶ 50.

[76] *Id.* ¶¶ 104a-123.

[77] *Id.* ¶¶ 55-61.

Petitioner, with no more than unsupported general suspicions of wrongdoing.

Second, nowhere in the SAC does Petitioner set forth the factual basis for his "information and belief" that Lincare engaged in the alleged fraud during the time periods and in the locations identified. Rather, his SAC merely generally asserts that "[i]n his capacity as a [Lincare] center manager [Petitioner] became aware of specific fraudulent acts and schemes perpetrated by Lincare through its employees."[78] However, while Petitioner worked "as a Center Manager for the South Orlando Center from August 15, 1995 to December 19, 1997,"[79] the SAC's "information and belief" allegations apply "***nationwide*** in every geographic location where these companies do business"[80] and stretch back ***at least a dozen years***.[81] Thus, it would appear impossible for Petitioner to have "bec[ome] aware" of his "information and belief" allegations as his SAC claims.

Therefore, Petitioner made no attempt to satisfy the corporate fraud exception to Rule 9(b)'s heightened pleading requirements. As such, the mere fact that Petitioner based a substantial percentage of his SAC's vague allegations on mere "upon information and belief" renders the complaint deficient and justified the district court's dismissal.[82]

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[78] *Id.* ¶ 171.

[79] *Id.* ¶ 5.

[80] *Id.* ¶ 104 (emphasis added).

[81] *Id.* ¶¶ 26, 32, 38, 51, 86, 111.

[82] *United States ex rel. Phipps v. Comprehensive Cmty. Dev. Corp.*, 152 F. Supp. 2d 443, 455 (S.D.N.Y. 2001).

b. NO WHO: The SAC Does Not Identify Who Submitted A False Claim To The Government.

FCA complaints must state the identity of the persons submitting the alleged false claim to the government.[83] However, Petitioner's SAC fails to identify any employee of Respondents who, or any particular billing office that, allegedly submitted a false claim or record to the government. These deficiencies alone justified the district court's dismissal.[84] The SAC then compounds these deficiencies by lumping Lincare and Rotech together with all or several of the other defendants in wholesale conclusory fashion at least a dozen times in the complaint.[85] Similar flaws were highlighted by the Sixth Circuit in *United States ex rel. Bledsoe v. Community Health Systems, Inc.*, 342 F.3d 634 (6th Cir. 2003), in which the Court held that FCA complaints "may not rely upon blanket references to acts or omissions by all of the 'defendants,' for each defendant named in the complaint is entitled to be apprised of the circumstances surrounding

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[83] *United States ex rel. Doe v. Dow Chem. Co.*, 343 F.3d 325, 329 (5th Cir. 2003) (holding that "the identity of the person making the misrepresentation" must be pleaded with particularity in a FCA case); *United States ex rel. Lee v. SmithKline Beecham Clinical Labs*, 245 F.3d 1048, 1051 (9th Cir. 2001); *Harrison v. Westinghouse Savannah River Co.*, 176 F.3d 776 (4th Cir. 1999); *United States v. Bouchey*, 860 F. Supp. 890, 893 (D.D.C. 1994) ("The claim . . . must state which individual made the misrepresentation."); *United States ex rel. Robinson v. Northrop Corp.*, 149 F.R.D. 142, 145 (N.D. Ill. 1993) (holding those filing false claims must be specifically identified and it is not enough to generically identify them by position in the company).

[84] *See Doe*, 343 F.3d at 329; *Cox*, 29 F. Supp. 2d at 1025; *United States v. EER Sys. Corp.*, 950 F. Supp. 130, 132 (D. Md. 1996); *United States ex rel. DeCarlo v. Kiewit/AFC Enters., Inc.*, 937 F. Supp. 1039, 1050 (S.D.N.Y. 1996) (emphasizing that "the complaint fails to refer to specific employees who may have been involved in submitting false claims").

[85] Petitioner's SAC lumps the defendants together when making allegations concerning kickbacks, Res. App. at 69 ¶¶ 23-25, 30, 38, improper completion of CMNs, *Id.* ¶¶ 55, 99, improper testing, *Id.* ¶¶ 104a, 109, 123, improper payment of Medicare co-pay obligations, *Id.* ¶ 49, and improper identification of potential Medicare patients, *Id.* ¶¶ 155, 163.

the fraudulent conduct with which he individually stands charged."[86] Thus, the SAC's collective references to Lincare and the other defendants effectively deprives them of notice and warrants the district court's dismissal.[87]

c. NO WHAT: The SAC Does Not Identify Any Specific False Claims.

Because submission of a false claim is the *sine qua non* of an FCA violation, FCA complaints must include a "description in the complaint of [a] discrete incident of the fraudulent submission of a claim by [the] defendant to the federal government."[88] Thus, as a general matter, FCA complaints must identify a particular false claim that was presented to the government in an effort to receive payment[89] and explain what is untrue about that particular claim.[90] As this Court noted in *Clausen*, "if Rule 9(b) is to be adhered to, some indicia of reliability must be given in the complaint to

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[86] *Bledsoe*, 342 F.3d 634, 643 (6th Cir. 2003) (noting that the complaint "often states that 'Defendants' engaged in certain practices, without ever specifying the defendants to which it was referring").

[87] *Id.*

[88] *United States ex rel. Atkins v. McInteer*, 345 F. Supp. 2d 1302, 1305 (N.D. Ala. 2004).

[89] *See, e.g., United States ex rel. Schmidt v. Zimmer, Inc.*, No. CIV-A-00-1044, 2005 WL 1806502, at *2 (E.D. Pa. July 29, 2005) (holding that "under Rule 9(b), relators must identify with particularity the precise claims submitted to the government that are alleged to be false or fraudulent"); *Yuhasz v. Brush Wellman, Inc.*, 181 F. Supp. 2d 785, 793 (N.D. Ohio 2001), aff'd, 341 F.3d 559 (6th Cir. 2003) (holding that 9(b) was not satisfied because the "[r]elator did not state a specific false claim submitted to the government"); *United States ex rel. Walsh v. Eastman Kodak Co.*, 98 F. Supp. 2d 141, 147 (D. Mass. 2000) ("Without citing a single false claim arising from an allegedly false invoice, Relator has not met even a bare-bones Rule 9(b) test."); *United States ex rel. Cox v. Iowa Health Sys.*, 29 F. Supp. 2d 1022 (S.D. Iowa 1998) (dismissing a FCA count because the complaint failed to identify any single false claim that the defendant actually submitted to the government).

[90] *See, e.g., United States ex rel. Butler v. Magellan Health Servs., Inc.*, 101 F. Supp. 2d 1365 (M.D. Fla. 2000); *United States v. Cheng*, 184 F.R.D. 399, 402 (D.N.M. 1998).

support the allegation of ***an actual false claim*** for payment being made to the Government."[91] This standard requires plaintiffs to plead enough of the descriptive and circumstantial identifiers of actual false claims to provide a meaningful factual basis for the conclusion that an actual false claim was filed. For example, in *United States ex rel. Karvelas v. Melrose-Wakefield Hospital*, the First Circuit identified the following facts that should generally be pleaded to satisfy this standard: (1) ***dates*** and ***false content*** of allegedly fraudulent claims, (2) ***identification numbers*** and ***amounts charged*** in the individual claims, and (3) the ***source of information*** that these claims were actually submitted.[92]

While there may be many different categories of details in a complaint that could satisfy this standard, it is clearly inadequate for plaintiffs "merely to describe a private scheme in detail but then to ***allege simply and without any stated reason for his belief that claims requesting illegal payments must have been submitted, were likely submitted or should have been submitted to the Government***."[93] This is exactly what Petitioner's SAC does.

Contrary to Petitioner's claim, the SAC did not identify "dozens of examples of individual [false] claims submitted" by Respondents Lincare and Rotech to the government for payment.[94] While broadly alleging that "***every***" claim for payment is "***false***" if submitted after some impropriety has occurred,[95] Petitioner's SAC does not identify a ***single*** specific false claim or ***one*** particular payment by the government that was made on a purported false claim. Rather, the SAC espouses a blanket theory of liability that ***any*** vaguely alleged impropriety in providing patient services or preparing paperwork for those services taints ***every*** claim

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[91] *Clausen*, 290 F.3d at 1311 (emphasis in original).

[92] *Karvelas*, 360 F.3d 220, 233 (1st Cir. 2004).

[93] 290 F.3d at 1311 (emphasis added).

[94] Pet. at 2.

[95] Res. App. at 69 ¶¶ 62, 65 (emphasis added).

that Lincare and Rotech subsequently submitted to the government for payment related to those services, even if the claim itself contained ***no false information***.[96]

Consequently, Petitioner's SAC contains little more than vague and conclusory allegations that the Respondents engaged in nationwide regulatory violations for over a dozen years and this misconduct should have resulted in submission of false claims. Petitioner "may not simply hypothesize that, based on [Lincare's] allegedly illegal . . . scheme, false claims must have been submitted."[97] Clearly, the SAC's allegations do not satisfy Rule 9(b).

d. NO WHEN OR WHERE: The SAC Fails To Identify Any Dates That Alleged False Claims Were Submitted To The Government Or Specifically Identify Where False Claims Originated From, Or Were Submitted To, The Government.

In order to satisfy Rule 9(b), Petitioner's SAC had to identify when[98] and where[99] the false claims were prepared, dispatched, or transmitted. However, the SAC asserts that the alleged misconduct was "***nationwide*** in every geographic location where these companies do business"[100] and stretched back ***at least a dozen years***.[101] As the district

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[96] *Id.*

[97] *United States ex rel. Schmidt*, 2005 WL 1806502, at *2.

[98] *See, e.g.*, *Lee*, 245 F.3d at 1051; *California ex rel. Mueller v. Walgreen Corp.*, 175 F.R.D. 631, 635 (N.D. Cal. 1997) (involving a state *qui tam* claim in federal court and ruling that F.R.C.P. 9(b) was not satisfied where the complaint did not indicate the exact time, place, and participants of the alleged fraud).

[99] *See, e.g.*, *United States ex rel. Vallejo v. Investronica, Inc.*, 2 F. Supp. 2d 330, 336-37 (W.D.N.Y. 1998) (holding that a qui tam relator must state the specific "***place where the alleged fraud took place***") (emphasis added).

[100] Res. App. at 69 ¶ 104 (emphasis added).

[101] *Id.* ¶¶ 26, 32, 38, 51 (alleged conduct occurred throughout the "late 1980's and 1990's."); ¶ 86 ("[f]rom before 1984 through 1997 and, upon belief, to the present"); ¶ 111 ("[t]hroughout the 1990s").

court correctly held in its March 9, 2001 Order dismissing the SAC with prejudice, its allegations were practically "***unlimited in time and geography***"[102] and, thus, did not comply with Rule 9(b).

First, the SAC casts the broadest temporal net imaginable, alleging that Lincare supposedly engaged in various improprieties "throughout the 1980s and 1990s," "during the entire statutory time period," and "throughout the 1990s."[103] The SAC contains no reference, however, to dates that any claim for payment based on an allegedly improper CMN was actually submitted to, or paid by, the government. Consequently, the SAC fails to identify ***when*** the alleged false claims occurred.

In addition, while Lincare and Rotech operated nationwide during the relevant period, the SAC never identifies where the alleged frauds took place. Instead, the SAC makes blanket accusations about "widespread practices" in broad geographic regions, such as "throughout the State of Florida," "in all places where Lincare does business," and "nationwide in every geographic location where these companies do business."[104] Clearly, these overbroad allegations fail to allege ***where*** Petitioner's alleged false claims violations transpired.

e. NO CONSPIRACY FACTS: The SAC Fails To Plead Any Necessary Elements Of The Alleged Conspiracy.

While Count I of Petitioner's SAC concludes that "Lincare and [Doctor] Varraux conspired to defraud the Government by getting false claims allowed or paid in violation of 31 U.S.C. § 3730(a)(3), and each committed numerous overt acts in furtherance thereof," the SAC fails to identify: (1) one such overt act, (2) the object of the conspiracy (other than the unclear goal of defrauding the government), (3) when or

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[102] Res. App. at 144-146 (emphasis added).

[103] *See* Res. App. at 69 ¶¶ 26, 32, 38, 51, 86, 111.

[104] Res. App. at 69 ¶¶ 28, 33, 51, 57, 104.

where the purported agreement was formed, or (4) how the alleged conspiracy operated.

The SAC's only other references to Dr. Varraux are in two separate paragraphs buried in the 56-page complaint that make conclusory allegations that Lincare "had a kick-back relationship with" Dr. Varraux "dating back to before 1990," pursuant to which Dr. Varraux "unbundled" Lincare prescriptions.[105] These broad and indefinite claims fail to provide Lincare with any notice of the following necessary elements of a FCA conspiracy charge: (1) the particular terms of the alleged agreement, (2) when the alleged agreement was formed, and (3) what specific overt acts were committed by Lincare and Dr. Varraux in furtherance of the alleged conspiracy.[106]

As stated in *United States ex rel. Drake v. Norden Sys., Inc.*, No. 3:94-CV-963, 2000 WL 1336497 at *12 (D. Conn. Aug. 24, 2000), a case involving a similar § 3739(a)(3) conspiracy claim,

> [t]he complaint merely alludes to an agreement between Defendants and does not specify the particulars of ***how*** and ***when*** that alleged conspiracy arose, who entered into it, or ***what act*** was committed in furtherance of the conspiracy. Such general allegations of conspiracy do not meet the particularity standards required by Fed. R. Civ. P. 9(b). . . . Consequently, Relator's . . . claim alleging an FCA § 3729(a)(3) conspiracy is dismissed . . .[107]

Like the plaintiff's claim in *Drake*, the SAC's conspiracy claims are fatally deficient and were properly dismissed by the district court.

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[105] *Id.* ¶¶ 41, 152.

[106] *See generally United States ex rel. Atkins*, 345 F. Supp. 2d at 1305 (specific overt act necessary for Rule 9(b) compliance); *Bouchey*, 860 F. Supp. at 893 (elements of FCA conspiracy).

[107] No. 3:94-CV-963, 2000 WL 1336497, at *12 (D. Conn. Aug. 24, 2000) (emphasis added) (*citing Center Cadillac, Inc. v. Bank Leumi Trust Co.*, 808 F. Supp. 213, 230 (S.D.N.Y. 1992), aff'd, 99 F.3d 401 (2d Cir. 1995)).

f. NO NOTICE: The SAC Fails To Provide Respondents With Sufficient Notice Of Petitioner's Claims.

Fair notice is "[p]erhaps the most basic consideration at issue under Rule 9(b),[108] and the rule is intended to enable [FCA] defendant[s] to respond specifically and quickly to the potentially damaging allegations" in FCA cases.[109] Rule 9(b)'s notice policy is acutely implicated in this case.

Petitioner's failure to plead his SAC with particularity forces Respondents to guess about the core allegations against it because the complaint ***never*** identifies: (1) the ***what*** (the particular claims, what made them false, and amounts of money charged), (2) the ***who*** (the individuals involved in preparing and submitting the false claims), (3) the ***when*** (the dates that these claims were created, submitted to, or paid by, the government), and (4) the ***where*** (the location of the billing office submitting the allegedly false claims). Instead, the SAC accuses Lincare of several broad fraudulent schemes, (1) engaged in by Lincare Inc. Lincare Holdings Inc. ***or*** one of their unnamed employees; (2) taking place at any time within a period longer than a decade;[110] (3) in some or all locations where Lincare operates;[111] and (4) that somehow resulted in the submission of thousands of unidentified false claims to the government.[112] Without the necessary particulars in Petitioner's SAC: (1) Respondents do not have sufficient notice of the conduct that Petitioner alleges constitutes fraud; (2) it cannot defend against the charges; and (3) it is restricted in its Answer to setting forth general denials of wrongdoing.

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[108] 5 Charles Alan Wright *et al.*, *Federal Practice & Procedure*, § 1298, at 648 (2d ed. 1990).

[109] *United States ex rel. Costner*, 317 F.3d at 888.

[110] Res. App. at 69 ¶¶ 26, 32, 38, 51, 86, 111.

[111] *Id.* ¶ 104.

[112] *Id.* ¶¶ 54, 154.

2. The District Court Did Not Abuse Its Discretion In Denying Petitioner's Untimely Motion To Amend His SAC And File A Proposed TAC.

On June 2, 2003, the district court denied Petitioner's belated motion to amend his SAC and file his proposed TAC because: (a) it was untimely,[113] (b) Petitioner failed to explain why he could not have included his TAC's new allegations in any of his 3 previous complaints,[114] and (c) "the detail Relator [sought] to add would not [have] ameliorate[d] the deficiencies which required dismissal" of his SAC.[115] The district court was well within its discretion to deny Petitioner's motion to amend. While the federal courts have a liberal policy regarding amending complaints, a plaintiff's motion to amend may be denied where, as in this case, "there has been undue delay, bad faith, dilatory motive, or repeated failure to cure deficiencies by amendments previously allowed."[116]

The district court's denial of Petitioner's motion to file the TAC was justified by the TAC's untimeliness. Petitioner waited years after the defendants moved to dismiss his SAC before he filed a motion for leave to amend SAC and file his TAC. Petitioner filed his TAC on October 18, 2002, which was: (1) over 4½ years after he left his position at Lincare and filed this action; (2) over 2 years and 10 months after he filed his SAC; (3) over 2 years and 9 months after the defendants first filed motions to dismiss his SAC, detailing that complaint's failure to satisfy Rule 9(b); (4) over 1 year and 7 months after the district court dismissed his claims against Lincare with prejudice; and (5) over 5 months after the Eleventh Circuit published its opinion in *United States ex rel. Clausen*.[117]

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[113] Res. App. at 166 (highlighting time between May *Clausen* decision and Corsello's October motion), *id.* at 167-168 (noting that Corsello waited over a year after SAC was dismissed and 5-6 months after *Clausen* decision).

[114] *Id.*

[115] *Id.* at 166. *See also id.* at 167-168.

[116] *Bryant v. Dupree*, 252 F.3d 1161, 1163 (11th Cir. 2001) (emphasis added).

[117] 290 F.3d 1301.

In addition, the district court was warranted in denying Petitioner's motion to file his proposed TAC because Petitioner failed to explain why he had not included its new allegations in any of his first three complaints. On this point, Petitioner claimed that the Eleventh Circuit's ruling in *Clausen*[118] "clarified" the standard for his action and somehow relieved him of a prior confusion concerning the proper interpretation of Rule 9(b) as it applies to *qui tam* complaints.[119] The district court did not find that this was an adequate explanation because (1) Petitioner failed to adequately explain why he made no attempt to include the information in his proposed TAC in any of his earlier complaints and (2) Petitioner waited 5 months after the *Clausen* decision to file the motion.[120] Such "unexplained tardiness constitutes undue delay" and warranted the district court's denial of his motion to amend.[121]

CONCLUSION

For the reasons set forth above, Petitioner Kirk S. Corsello's petition for certiorari should not be granted.

Respectfully submitted,

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[118] 290 F.3d 1301.

[119] Res. App. at 165-166.

[120] Res. App. at 171-173.

[121] *Carruthers v. BSA Advertising, Inc.*, 357 F.3d 1213, 1218 (11th Cir. 2004).

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES EX REL. KIRK S. CORSELLO AND KIRK S. CORSELLO. Plaintiff, v. LINCARE, INC., LINCARE HOLDINGS, INC., LINCARE HEALTHCARE GROUP, INC., JOHN P. BYRNES, LORI DEMELLO, LARRY SIMMONS, LYNN GARAPIC, RON PLUCHEL, AHP HOME HEALTH CARE, INC., RESPICARE OF CENTRAL FLORIDA, INC., MEDICAL OPTIONS, INC., ROTECH, INC., WEST MEDICAL, OXY PLUS OF ORLANDO, INC., APRIA, ORLANDO REGIONAL HEALTHCARE SYSTEM, INC., PRINCETON HOSPITAL, INC., ROMEO G. GUZMAN, M.D., R.G. GUZMAN, M.D., P.A. FAMILY AND GERIATRIC MEDICINE, ALAN VARRAUX, M.D., YASMEEN GOWANI, M.D., LUIS F. BAROROSO GANESH AKULA, AMRUTH BAPATLA, RAZA ALI, MORRIS T. BIRD, ALFRED BOOKHARDT, IVAN CASTRO, WINTER PARK INTERNAL MEDICINE, M.D.,	**CIVIL ACTION NO.** **Jury Trial Requested** **TO BE FILED *IN CAMERA* AND UNDER SEAL** **98-CV-0204-ODE**

P.A., FRANCIS J. COVELLI, DON R. COX, ALAN M. DENNER, GERMAN ESCANO, JEROLD FADEM JR., JENNIFER BISHOP, FAISAL FAKIH, TOLLIVER L. HIGGINS, H.B. KARUNARTNE, VAJAH KHAN, ASHOK K.H. KHANNA, MOHAMMAD LATIF, DANIEL MANCINI, CHARLES MELLA, ORANGE COUNTY MEDICAL CENTER, FINANCE DEPARTMENT OF ORANGE COUNTY, NICHOLAS PASTIS, LAC PHAM, ROBERT SNYDER, DENNIS STEVENSON, E. ROGER ALILIN, FLORIDA HEART GROUP, LINDA WASSERMAN, CHARLES H. R. MOOREFIELD, JAY PHAM, WINTER PARK MEMORIAL HOSPITAL ASSOCIATION, INC., JOHN DOES and JOHN DOE CORPORATIONS 1-99

Defendants.

COMPLAINT

(Filed Jan. 22, 1998)

Plaintiff-Relator Kirk S. Corsello ("Relator") hereby files the following Complaint and alleges as follows:

I.

JURISDICTION AND VENUE

1. This action arises under the False Claims Act, as amended, 31 U.S.C. §§ 3729-3733, and at common law.

2. This Court has subject matter jurisdiction over this action pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1345.

3. This Court has personal jurisdiction over the Defendants.

4. Venue is proper in this district under 28 U.S.C. §§ 1391(b), and 1391(c), and under 31 U.S.C. § 3732(a). At least one Defendant can be found, resides, and transacts business within the district, and the acts proscribed by the False Claims Act occurred within the district.

THE PARTIES

5. Relator **Kirk S. Corsello** is a citizen of the United States and formerly worked for Lincare as a Center Manager for the South Orlando Center.

DME DEFENDANTS

6. Defendant **Lincare, Inc.** is incorporated in the State of Delaware and its corporate headquarters are in Clearwater, Florida.

7. Defendant **Lincare Holdings, Inc.** is incorporated in the State of Delaware and its corporate headquarters are in Clearwater, Florida.

8. Defendant **Lincare Healthcare Group, Inc.** has its corporate headquarters are [sic] in Clearwater, Florida.

9. Defendant **John P. Byrnes** is the President for the Defendant Lincare with its offices located at 19337 U.S. 19 North, Clearwater, Florida 34624.

10. Defendant **Lori Demello** is the Area Manager for Defendant Lincare the offices for which are located at 1701 South Alexander Street, Plant City, Florida 33567.

11. Defendant **Larry Simmons** is the Area Manager for Defendant Lincare the offices for which are located at 224 W. Central Parkway, Suite 1016. Altamonte Springs, Florida 32714-2545.

12. Defendant **Lynn Garapic** is the Sales Representative for Defendant Lincare the offices for which are located at 224 W. Central Parkway, Suite 1016, Altamonte Springs, Florida 32714-2545.

13. Defendant **Ron Pluchel** is the Center Manager for Defendant Lincare the offices for which are located at 224 W. Central Parkway, Suite 1016, Altamonte Springs, Florida 32714-2545.

14. Defendant **AHP Home Health Care, Inc.** is incorporated in the State of Florida and its corporate headquarters are in Jacksonville, Florida.

15. Defendant **Respicare of Central Florida, Inc.** is incorporated in the State of Florida and its corporate headquarters are in Altimonte [sic] Springs, Florida.

16. Defendant **Medical Options, Inc.** is incorporated in the State of Florida and its corporate headquarters are in Orlando, Florida.

17. Defendant **Rotech, Inc.** is incorporated in the State of Florida and its corporate headquarters are in Aventura, Florida.

18. Upon information and belief, Defendant **West Medical** is a corporation or partnership d/b/a West Medical which fictitious name was registered with the Florida Secretary of State.

19. Defendant **Oxy Plus of Orlando, Inc.** is incorporated in the State of Florida and its corporate headquarters are in Altamonte Springs, Florida.

20. Defendant **Apria** is incorporated in the State of Delaware, and its corporate headquarters are in Costa Mesa, California. Apria's business address in Atlanta, Georgia is 8601 Dunwoody Place, #136, Atlanta, Georgia 30350. Apria is one of the largest home health care providers in the United States, supplying home respiratory therapy and medical equipment to patients around the country.

REFERRING PHYSICIAN DEFENDANTS

21. Defendant **Orlando Regional Healthcare System, Inc.** is incorporated in the State of Florida and its corporate headquarters are in Orlando, Florida.

22. Defendant **Princeton Hospital, Inc.** is incorporated in the State of Florida and its corporate headquarters are in Orlando, Florida.

23. Defendant **Romeo G. Guzman, M.D.** is a medical practitioner.

24. Defendant **R. G. Guzman, M.D., P.A.** Family and Geriatric Medical Clinic is a professional medical corporation formed under Florida law and its business headquarters are in Orlando, Florida.

25. Defendant **Alan Varraux, M.D.** is a pulmonologist medical practitioner.

26. Defendant **Yasmeen Gowani, M.D.** is a pulmonologist medical practitioner.

27. Defendant **Ganesh Akula** is a pulmonologist medical practitioner.

28. Defendant **Amruth Bapatla** is a pulmonologist medical practitioner.

29. Defendant **Raza Ali** is a medical practitioner.

30. Defendant **Morris T. Bird** is a director of sleep lab and a medical practitioner.

31. Defendant **Alfred Bookhardt** is a medical practitioner.

32. Defendant **Ivan Castro** is a medical practitioner.

33. Defendant **Winter Park Internal Medicine, M.D., P.A.** is a professional medical corporation formed under Florida law and its business headquarters are in Winter Park, Florida.

34. Defendant **Francis J. Covelli** is a pulmonologist medical practitioner.

35. Defendant **Don R. Cox** is a medical practitioner.

36. Defendant **Alan M. Denner** is a medical practitioner.

37. Defendant **German Escano** is a pulmonologist medical practitioner.

38. Defendant **Jerold Fadem, Jr.** is a medical practitioner.

39. Defendant **Jennifer Bishop** is the office manager for Dr. Fadem.

40. Defendant **Faisal Fakih** is a pulmonologist medical practitioner.

41. Defendant **Tolliver L. Higgins** is a medical practitioner.

42. Defendant **H. B. Karunartne** is a medical practitioner.

43. Defendant **Vajah Khan** is a medical practitioner.

44. Defendant **Ashok K. Khanna** is a medical practitioner.

45. Defendant **Mohammad Latif** is a medical practitioner.

46. 41 [sic]. Defendant **Daniel Mancini** is a medical practitioner.

47. Defendant **Charles Mella** is a medical practitioner.

48. Defendant **Orange County Medical Center** is part of a municipality in the State of Florida.

49. Defendant **Finance Department of Orange County** is part of a municipality in the State of Florida.

50. Defendant **Nicholas Pastis** is a medical practitioner.

51. Defendant **Lac Pham** is a medical practitioner.

52. Defendant **Robart** [sic] **Snyder** is a pulmonologist medical practitioner.

53. Defendant **Dennis Stevenson** is a medical practitioner.

54. Defendant **E. Roger Alilin** is a medical practitioner.

55. Defendant **Florida Heart Group** is a professional medical corporation formed under Florida law and its business headquarters are in Orlando, Florida.

56. Defendant **Linda Wasserman** is a medical practitioner.

57. Defendant **Charles H. R. Moorefield** is a medical practitioner.

58. Defendant **Jay Pham** is a medical practitioner.

59. Defendant **Winter Park Memorial Hospital, Association, Inc.** is incorporated in the State of Florida and its corporate headquarters are in Winter Park, Florida.

60. Realtor [sic] **Kirk S. Corsello** is also pursuing claims for relief against Defendants listed as John Does and John Doe Corporations 1-99 because, while they have been or are participating with the specific Defendants named in this Complaint in presenting or causing to be presented false or fraudulent claims to the United States, their names presently are not

known to Relator Kirk S. Corsello. Certain of the John Doe Defendants work for Lincare and other DME Defendants. However, the vast majority of John Doe Defendants are Referring Physician Defendants.

STATEMENT OF FACTS
THE MEDICARE AND MEDICAID PROGRAMS

61. Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.*, establishes the Health Insurance for the Aged and Disabled Program, popularly known as the Medicare program. The Secretary of HHS administers the Medicare Program through HCFA, a component of HHS.

62. The Medicare program is comprised of two parts. Part A provides basic insurance for the costs of hospitalization and post-hospitalization care. 42 U.S.C. §§ 1395c-1395i-2 (1992).

63. Part B is a federally subsidized, voluntary insurance program that covers a percentage (typically eighty percent) of the fee schedule amount for physician and laboratory services. 42 U.S.C. §§ 1395k, 1395l, 1395x(s). Reimbursement for Medicare claims is made by the United States through HCFA. HCFA, in turn, contracts with private insurance carriers to administer and pay Part B claims from the Medicare Trust Fund. 42 U.S.C. § 1395u. In this capacity, the carriers act on behalf of HCFA. 42 C.F.R. § 421.5(b) (1994).

64. Medicaid is a federally assisted grant program for the States. Medicaid enables the States to provide

medical assistance and related services to needy individuals. HCFA administers Medicaid on the federal level. Within broad federal rules, however, each state decides who is eligible for Medicaid, the services covered, payment levels for services and administrative and operation procedures. The state directly pays physicians, with the state obtaining the federal share of the payment from accounts, which draw on funds of the United States Treasury. 42 C.F.R. §§ 430.0-430.30 (1994). The Federal share of each State's Medicaid program varies state by state.

65. At all times relevant to this Complaint, the United States provided funds to the States through the Medicaid program, pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* Enrolled providers of medical services to Medicaid recipients are eligible for reimbursement for covered medical services under the provisions of Title XIX of the 1965 Amendments to the Federal Social Security Act. By becoming a participating provider in Medicaid, enrolled providers agree to abide by the rules, regulations, policies and procedures governing reimbursement, and to keep and allow access to records and information as required by Medicaid. In order to receive Medicaid funds, enrolled providers, together with authorized agents, employers, and contractors, are required to abide by all the provisions of the Social Security Act, the regulations promulgated under the Act, and all applicable policies and procedures issued by the State.

66. Among the rules and regulations which enrolled providers agree to follow are to: (1) bill the DMA or DMERC for only those covered services which are

medically necessary; (2) neither bill the DMA or DMERC for any services or items which were not performed or delivered in accordance with all applicable policies nor submit false or inaccurate information to the Department relating to provider costs or services, (3) not engage in any act or omission that constitutes or results in overutilization of services; (4) not engage in any activity such as obtaining a list of Medicaid eligibles or canvassing neighborhoods for direct contact with Medicaid eligibles, or the payment of a referral or other fee which is not in compensation for medical care rendered to the recipient; (5) be fully licensed and/or certified under the applicable state and federal laws to perform the services provided to recipients; (6) comply with state and federal statutes, policies and regulations applicable to the Medicaid Program; (7) not engage in any illegal activities related to the furnishing of services to recipients.

67. At all times relevant to this Complaint, the DME Defendants were participating Medicare Part B providers. The DME Defendants submitted claims to Medicare for services and durable medical equipment.

68. At all times relevant to this Complaint, the Medicare and Medicaid programs constituted a significant source of gross patient revenue for the DME Defendants.

SUBMISSION OF FALSE CLAIMS

69. Defendants **Lincare, Inc., Lincare Holdings, Inc., Lincare Healthcare Group, Inc., John P. Byrnes, Lori Demello, Larry Simmons, Lynn Garapic**, and **Ron Pluchel** are collectively referred to as "Lincare" Defendants.

70. Defendants **Lincare, AHP Home Health Care, Inc., Respicare of Central Florida, Inc., Medical Options, Inc., Rotech, Inc., West Medical, Oxy Plus of Orlando, Inc.**, and **Apria** are referred to as "DME" Defendants.

71. Defendants **Orlando Regional Healthcare System, Inc., Princeton Hospital, Inc., Romeo G. Guzman, M.D., R. G. Guzman, M.D., P.A. Family and Geriatric Medicine, Alan Varraux, M.D., Yasmeen Gowani, M.D., Luis F. Baroroso, Ganesh Akula, Amruth Bapatla, Raza Ali, Morris T. Bird, Alfred Bookhardt, Ivan Castro, Winter Park Internal Medicine, M.D., P.A., Francis J. Covelli, Don R. Cox, Alan M. Denner, German Escano, Jerold Fadem, Jr., Jennifer Bishop, Faisal Fakih, Tolliver L. Higgins, H. B. Karunartne, Vajah Kahn, Ashok K. H. Khanna, Mohammad Latif, Daniel Mancini, Charles Mella, Orange County Medical Center, Finance Department of Orange County, Nicholas Pastis, Lac Pham, Robert Snyder, Dennis Stevenson, E. Roger Alitin, Florida Heart Group, Linda Wasserman, Charles H. R. Moorefield, Jay Pham, Winter Park Memorial Hospital, Association, Inc.** and most John Doe and John Doe

Corporations 1-99 are referred to as "Referring Physician" Defendants.

72. Lincare Defendants and other DME Defendants have pursued a scheme to defraud the United States by engaging in extensive kickbacks to Referring Physician Defendants as an inducement for Referring Physician Defendants to refer patients, including Medicare and Medicaid patients, requiring durable medical equipment and home health services to Lincare and other DME Defendants.

73. Certain of the DME Defendants camouflaged some of the kickbacks with contractual arrangements with certain Referring Physician Defendants including varieties of "consulting arrangements" or other programs intending to pay Referring Defendant Physicians for duties already owed to shared patients by virtue of the physician/patient relationship. The actual and primary purpose of these arrangements was to ensure that the Referring Physician Defendants referred patients to the specific DME Defendant with whom the Referring Physician had a contractual relationship. While this was an effective method for obtaining referrals, certain of the Referring Physician Defendants would have kickbacks from various DME Defendants. Accordingly, certain DME Defendants would closely track the value of their kickback arrangements with Referring Physician Defendants to determine whether the level of patients referred justified the kickbacks. Appropriate adjustments were then made.

74. The kickback schemes did not only encompass direct payments for referrals.

75. Certain of the DME Defendants camouflaged some of the kickbacks in lease arrangements with certain of the Referring Physician Defendants. Sometimes DME Defendants would lease unnecessary space from a Referring Physician Defendant and sometimes DME Defendants would lease space to Referring Physician Defendants. In either case, the lease was secondary to the purpose of hiding the kickback.

76. Certain of the DME Defendants camouflaged some of the kickbacks in the provision of free or extremely reduced prices on equipment for certain of the Referring Physician Defendants or their patients. This included any of the durable medical equipment sold by the DME Defendants as well as monitoring devices such as oximeters.

77. One of the more disturbing practices involving kickbacks was the DME Defendants' provision of services for the Referring Physician Defendants while allowing the Referring Physician Defendants to bill Medicare for the services. For certain DME Defendants and certain Referring Physician Defendants this common practice included, *inter alia*, services such as pulmonary function testing, pulse oximerry testing, spiromitry, heart monitoring and titrations. Certain DME Defendants provide discharge services for certain Defendant Hospitals for free with the requisite ability to refer a greater number of patients to the DME Defendant providing the service.

78. Certain DME Defendants provide medicine and equipment to Referring Physician Defendants who in turn can give them to patients. This includes, but is not limited to oximeters, oxygen, nebulizers, and medications.

79. Certain of the DME Defendants camouflaged some of the kickbacks in the form of free goods or benefits to certain Referring Physician Defendants' patients. Among other things this included the waiver of the mandatory 20% co-payment for Medicare patients. Certain of the DME Defendants would often "comp" it or make it complimentary in order to induce referrals.

80. Another of the more disturbing practices involving kickbacks concerns the illegal storage and dispersal of medications by certain DME Defendants. When certain DME Defendants' drivers visit the home of a patient who has too much medicine the driver will occasionally pick up the medicine and bring it back to the office for storage. Then when certain DME Defendants wanted to induce referrals from certain Referring Physician Defendants, they would take from this store of illegal medicines to provide to that Referring Physician Defendants' patient on an emergency basis or as a "starter dose".

81. Certain Referring Physician Defendants would not only refer patients for kickbacks, but would also prescribe unnecessary or more costly durable medical equipment, medications, or services to allow certain DME Defendants to improperly charge Medicare the unnecessary costs. For example, certain medications allowed DME Defendants to make twice the profit of other medications. Another example is uncapped durable medical equipment or changing the prescription for durable medical equipment before the cap period is reached in order to allow for a longer billing cycle.

82. All Defendants conspired in these and other ways to cost the United States Government more money for improper or unnecessary goods and services. Like

tax evaders looking for a loophole, certain DME Defendants pushed their employees to stay one step ahead of Medicare enforcement personnel by pushing different durable medical equipment, medicine, or services on Medicare patients.

83. Indeed, certain DME Defendants trolled for Medicare patients in order to "qualify" them for more costly or profitable services. Certain DME Defendants would send refills of medicines for patients who already had too much medicine in order that the DME Defendant could bill Medicare. Often this was done under the guise of "compliance" with physician orders when in reality it was a measure to push the profitability of the Medicare program for the DME Defendant to a maximum efficiency. Certain DME Defendants would be allowed unfettered access to certain Referring Physician Defendants' patient records. In the records, certain DME Defendants would find patients who were not yet prescribed all of the most profitable medicines, equipment, or services available which "oversight" would immediately be rectified by the DME Defendant. Certain DME Defendants would troll their own patient lists to make sure that every Medicare patient had every allowable service, medicine, and piece of equipment that any other similar patient was allowed regardless of whether or not the physician had prescribed it. Certain DME Defendants would bill Medicare for changes in patient's requirements without ever having the patient see the treating physician.

84. Certain DME Defendants "lose" patients because the patients no longer meet the Medicare requirements. These Defendants continue to troll these patients making every effort to "re-qualify" these patients.

85. Certain DME Defendants attempt to get lists of Medicare patients from various physicians by proposing to teach patients how to use certain durable medical equipment, such as an inhaler, for free.

86. For a variety of reasons, certain DME Defendants have engaged in a pattern and practice of receiving signed, but otherwise blank, certification of medical necessity from certain of the Referring Physician Defendants and using DME Defendants' staff to complete portions of the certificates a physician or staff member is authorized to complete. Certain DME Defendants have engaged in a pattern and practice of forging information on prescriptions including, but not limited to, the physician's signature. With certain DME Defendants this practice is so prevalent that certain employees insist on stockpiling a variety of different colored and styled pens to assist in forging prescriptions and defrauding Medicare. One or more of the DME Defendants has even given this practice the code name of "Doctor Papsmear". This is done in violation of 42 U.S.C. § 1395m(i)(2)(A)(iii) and/or 42 U.S.C. § 1320a-7a(1). The referring Physician Defendants, by providing signed but otherwise blank certificates of medical necessity, have knowingly caused and continue to cause false and fraudulent claims to be submitted to the United States by DME Defendants, in violation of 31 U.S.C. § 3729. By this practice, certain DME Defendants have billed Medicare for unauthorized medicine, equipment, and services.

87. Certain DME Defendants and Referring Physician Defendants conspired to leave parts of the prescriptions blank so that the DME Defendants could make changes to the physician's orders such as a change to or from liquid oxygen.

88. Certain DME Defendants have engaged in a pattern and practice of manipulation to attempt to get potential patients to qualify for goods or services. For example, certain drivers have been known to walk patients to and from the mailbox several times if the initial oximerry reading was too low. The falsification of prescriptions and other identifications of needs also falls into this category. Employees of certain DME Defendants will order medicines without the patients permission because it is a pattern and practice and because incentive programs are set up to reward such employees for increased use of medications.

89. Certain Referring Physician Defendants are looking for any additional money. Certain DME Defendants try to assist Referring Physician Defendants in using different codes to get more money from Medicare.

90. Certain DME Defendants have also provided medical equipment for their patients prior to or entirely without the proper prescriptions or other documentation. Certain medicines and equipment have also been provided to patients for free in order to show certain Referring Physician Defendants that the medicine and/or equipment is needed. Certain DME Defendants will also recover equipment from patients who have passed on and [illegible] the equipment even if the patient had purchased the equipment or it had been "capped out".

91. One result from many of the schemes perpetuated on the Medicare program is that patient care depends on the profitability under Medicare reimbursement of the products or services rather than what is important for proper patient care. As an example, one or more DME Defendants provided ultrasonic nebulizers because they thought they were "uncapped

items" under the Medicare guidelines; however, when the DME Defendants learned that the ultrasonic nebulizers were not reimbursable, all patients were swapped out for "billable services". Also, certain DME Defendants sought out Referring Physician Defendants to change medications for patients because the profitability of some medications was higher than others under the Medicare guidelines. Certain DME Defendants also fail to provide good service in order to save money. For example certain DME Defendants fail and refuse to check equipment such as concentrators. Certain DME Defendants also submit bills to Medicare after patients no longer require service including but not after the death of the patient.

92. Kirk S. Corsello was previously employed by Defendant Lincare as a center manager in Orlando.

93. In his capacity as a center manager, Mr. Corsello became aware of specific fraudulent acts involving Defendant Lincare.

94. In addition, Mr. Corsello learned facts indicating that Defendant Lincare was involved in other fraudulent activities also involving the other Defendants.

95. Mr. Corsello investigated the fraud, made reports of the fraud, and threatened to bring the fraud to public scrutiny.

96. Mr. Corsello was threatened and believed himself to be in personal danger for his investigations, discoveries, and threatened exposure.

97. Defendant Lincare discharged Kirk S. Corsello from his position as branch manager in violation of 31 U.S.C. § 3730(h).

COUNT I
Violation of 31 U.S.C. § 3729(a)(1)

98. Relator hereby incorporates and re-alleges herein Paragraphs 1-93 as fully set forth herein.

99. As set forth above, Defendants by and through their agents, officers and employees, knowingly presented, caused to be presented, or conspired to present to an officer or employee of the United States numerous false or fraudulent claims for payment or approval, in violation of 31 U.S.C. § 3729(a)(1).

100. The United States has been damaged as a result of Defendants' violations of the False Claim Act in an amount to be proven at trial. Relator is entitled to this sum as reimbursement for monies obtained by the Defendants for fraudulent claims submitted to the United States.

101. Relator is entitled to treble damages based upon the amount of damage sustained by the United States as a result of Defendants' violations of 31 U.S.C. § 3729(a)(1)-(3).

102. Relator is entitled to a civil penalty of between $5,000 and $10,000 as required by 31 U.S.C. § 3729(a) for each of Defendants' fraudulent claims.

103. Plaintiff also entitled to reasonable attorney fees and costs, pursuant to 31 U.S.C. § 3730(d)(1).

COUNT II
CONSPIRACY TO DEFRAUD
THE UNITED STATES

104. Relator Kirk S. Corsello hereby incorporates and re-alleges, herein paragraphs 1 through 99 as set forth fully herein.

105. Defendants have agreed to undermine the laws, rules, and regulations governing Medicare and Medicaid in the United States. Defendants have conspired with each other and others to defraud the government by the payment and acceptance of kickbacks and by acting collectively to submit or cause to be submitted false and fraudulent claims for payment to the United States in violation of 31 U.S.C. § 3729(a)(3).

106. The United States has been damaged as a result of Defendants' actions in violation of 31 U.S.C. § 3729(a)(3) in an amount to be proven at trial.

107. Relator is entitled to treble damages based upon the amount of damage sustained by the United States as a result of Defendants' violations of 31 U.S.C. § 3729(a)(1)-(3).

108. Relator is entitled to a civil penalty of between $5,000 and $10,000, as required by 31 U.S.C. § 3729(a), for each of Defendants' fraudulent claims.

109. Relator is also entitled to reasonable attorneys fees and costs, pursuant to 31 U.S.C. § 3730(d)(1).

COUNT III
WRONGFUL TERMINATION
(AGAINST DEFENDANT LINCARE)

110. Plaintiff also entitled to reasonable attorney fees and costs, pursuant to 31 U.S.C. § 3730(d)(1).

111. Relator Kirk S. Corsello hereby incorporates and realleges herein paragraphs 1 through 105 as if set forth fully herein.

112. Lincare terminated Relator Corsello in express violation of 31 U.S.C. § 3730(f).

113. Pursuant to this statute, Relator Corsello is entitled to be reinstated at the same level of seniority he would have enjoyed absent this termination; an award of two times the amount of back pay due plus interest; compensation for special damages; and litigation costs and reasonable attorney's fees.

PRAYER FOR RELIEF

WHEREFORE, Relator Kirk S. Corsello prays for judgment:

(a) ordering Defendants to pay the United States Government damages sustained by it for each of the false claims presented or caused to be presented plus interest, attorney's fees, and costs;

(b) ordering Defendants to pay the United States government a civil penalty of $10,000 as required by law to be assessed against each named Defendant for each of the false claims presented or caused to be presented;

(c) ordering treble damages based upon the amount of damages sustained by the United States government as a result of the false claims;

(d) ordering Lincare to reinstate Relator Corsello with the level of seniority he would have but for the discrimination; award two times the amount of back pay due to Relator Corsello, plus interest; compensate Relator Corsello for special damages, litigation costs and reasonable attorneys fees;

(e) granting such other relief as the Court may deem just and proper.

Respectfully submitted,

/s/ Mike Bothwell
MIKE BOTHWELL
Georgia Bar. No. 069920
Counsel for Relator
Kirk S. Corsello

595 Colonial Park Drive
Suite 302
Roswell, Georgia 30075
Telephone: (770) 643-1606

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA ex rel. KIRK S. CORSELLO, and KIRK S. CORSELLO Plaintiffs, v. LINCARE, INC. et al., Defendants.	CIVIL ACTION NO. 1:98-CV-0204-ODE

ORDER

(Filed Jun. 18, 1999)

This civil action, filed pursuant to the False Claims Act, 31 U.S.C. § 3730, is before the court on Defendant Rotech's opposed motion to unseal the court file, Defendant Rotech's motion to dismiss or in the alternative for a more definite statement, and Plaintiff's motions to extend time to serve complaint and to file an amended complaint under seal.

While Defendant Rotech has not as yet been served with the complaint, it seeks to dismiss the instant action, or in the alternative, seeks a more definite statement because it contends that Plaintiff has not fully complied with Fed.R.Civ.P. 9(b).

The complaint was unsealed in this action on November 6, 1998. However, Plaintiff has failed to perfect service upon any Defendants. Plaintiff contends that it has not served any of the parties because it anticipated filing an amended complaint. Plaintiff seeks to file an amended

complaint in order to add and dismiss certain parties to this action.

This complaint was originally filed January 2, 1998 and has now been pending before this court for well over one year. While Plaintiff contends that it has anticipated filing an amended complaint all along, he did not file his action until March 9, 1999, over four months after the undersigned unsealed the complaint. The *Qui Tam* Act was not enacted in order to give the relator an unlimited opportunity to perfect its complaint or the government an unlimited opportunity to elect to intervene. However, in consideration of judicial economy and in light of the fact that none of the parties to this action have yet been served, the court hereby GRANTS Plaintiff's motion for leave to amend the complaint. Plaintiff shall submit an amended complaint within ten (10) days of the entry of this order. The amended complaint shall fully comport with the requirement of Fed.R.Civ.P. 9(b), which requires that fraud be plead with specificity. "The plaintiff's complaint must allege the details of the defendant's allegedly fraudulent acts, when they occurred, and who engaged in them." *Cooper v. Blue Cross and Blue Shield of Florida*, 19 F.3d 562 568 (11th Cir. 1994). There will be no further extensions of time.

Plaintiff's request to file the amended complaint under seal, thereby affording the government an opportunity to elect to intervene, is DENIED. The court finds that Plaintiff has misinterpreted the *Qui Tam* Act. The procedural requirements of 31 U.S.C. § 3730(b)(2), that the complaint is to be filed in camera, that the complaint shall remain under seal for a sixty (60) day period, and that the United States may elect to intervene during that sixty (60) day period, "appl[y] only to the filing of the 'original

complaint' and do [] not apply to any amended complaint." *Wisz ex rel. United States v. C/HCA Development, Inc.*, 31 F.Supp.2d 1068, 1069 (N.D.Ill. 1999); see also, *U.S. Ex Rel Mikes v. Straus*, 931 F.Supp. 248, 258 (S.D.N.Y. 1996). Therefore, the sixty day period within which the United States may decide to intervene does not begin anew with the filing of the Relator's first amended complaint. The amended complaint will allege the same type of fraudulent conduct as the original complaint, which the United States has had more than an ample opportunity to review. 31 F.Supp.2d at 1069. Therefore, the complaint shall not be filed underseal and it shall be served upon all named defendants within twenty (20) days of filing.

Accordingly, Plaintiff's motion to extend the time to serve the complaint [#27-1] is hereby GRANTED. Plaintiff's motion to file an amended complaint under seal [#27-2] is hereby GRANTED-IN-PART and DENIED-IN-PART. Defendant Rotech's motion to dismiss [#22-1], motion for a more definite statement [#22-2], and motion to unseal the court file [#20] are hereby DISMISSED WITHOUT PREJUDICE. Defendant Rotech may refile the above motions should the need so arise. As the court has already lifted the seal on the complaint, the Government's motions [11-1] and [11-2] are hereby DENIED as MOOT.

SO ORDERED, this 18 day of June, 1999.

/s/ Orinda D. Evans
ORINDA D. EVANS
UNITED STATES
DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA ex rel. KIRK S. CORSELLO, and KIRK S. CORSELLO Plaintiffs, v. LINCARE, INC. et al., Defendants.	CIVIL ACTION NO. 1:98-CV-204-ODE

ORDER

(Filed Aug. 25, 1998)

This civil action, filed pursuant to the False Claims Act, 31 U.S.C. § 3730, is before the court on Plaintiff's opposed motion for an extension of time to file an amended complaint.

Having read and considered the parties' briefs and in light of Plaintiff's counsel's situation at the time filing was due, the court will grant Plaintiff's motion for an extension of time.

Accordingly, Plaintiff's motion for an extension of time to file an amended complaint [#31] is hereby GRANTED.

SO ORDERED, this 25 day of August, 1999.

/s/ Orinda D. Evans
ORINDA D. EVANS
UNITED STATES
DISTRICT JUDGE

UNITED STATES DISTRICT COURT
NORTH DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES EX REL. KIRK S. CORSELLO AND KIRK S. CORSELLO Plaintiffs, v. LINCARE, INC., LINCARE HOLDINGS, INC., JOHN P. BYRNES, LORI DEMELLO, SHAWN SCHABEL, LARRY SIMMONS, GREGG [sic] MCCARTHY, MARK TOBIN, LYNN GARAPIC, RON PLUCHEL, ROTECH, INC., AMERICAN HOME PATIENT, INC., ROMEO G. GUZMAN, M.D., R. G. GUZMAN, M.D., P.A. FAMILY AND GERIATRIC MEDICINE, ALAN VARRAUX, M.D., WINTER PARK INTERNAL MEDICINE, M.D., P.A., IVAN CASTRO, TOLLIVER L. HIGGINS, JOHN DANIEL MANCINI, JOHN DOES and JOHN DOE CORPORATIONS 1-99, Defendants.	CIVIL ACTION NO. 1:98-CV-0204-ODE **Jury Trial Requested**

AMENDED COMPLAINT

(Filed Jul. 14, 1999)

Plaintiff/Relator Kirk S. Corsello ("Relator") hereby files the following Amended Complaint and alleges as follows:

JURISDICTION AND VENUE

1. This action arises under the False Claims Act, as amended, 31 U.S.C. §§ 3729-3733, and at common law.

2. This Court has subject matter jurisdiction over this action pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1345.

3. This Court has personal jurisdiction over the Defendants.

4. Venue is proper in this district under 28 U.S.C. §§ 1391(b), and 1391(e), and under 31 U.S.C. § 3732(a). At least one Defendant can be found, resides, and transacts business within the district, and the acts proscribed by the False Claims Act occurred within the district.

THE PARTIES

5. Relator Kirk S. Corsello is a citizen of the United States and formerly worked for Lincare as a Center Manager for the South Orlando Center.

DME DEFENDANTS

6. Defendant **Lincare, Inc.** is incorporated in the State of Delaware with its principal place of business at 1937 U.S. 19 N., Suite 500, Clearwater, Florida 33764. Its registered agent for service of process is C.T. Corp., 1200 S. Pine Island Road, Plantation, Florida 33324.

7. Defendant **Lincare Holdings, Inc.** is incorporated in the State of Delaware with its principal place of business at 1937 U.S. 19 N., Suite 500, Clearwater, Florida 33764. Its registered agent for service of

process is C.T. Corp., 1200 S. Pine Island Road, Plantation, Florida 33324.

8. Defendant **John P. Byrnes** is the President for Defendant Lincare and can be served with process at 1937 U.S. 19 North, Suite 500, Clearwater, Florida 33764.

9. Defendant **Lori Demello** is a Regional Vice President for Defendant Lincare Defendant and can be served with process at 1937 U.S. 19 North, Suite 500, Clearwater, Florida 33764.

10. **Shawn Schabel** is a Regional Vice President for Defendant Lincare and can be served with process at 1937 U.S. 19 North, Suite 500, Clearwater, Florida 33764.

11. Defendant **Larry Simmons** was an Area Manager for Defendant Lincare and can be served with process through his attorney, William W. Carrier, III, Tydings & Rosenberg, LLP, 100 East Pratt Street, Baltimore, Maryland 21202.

12. located at 224 W. Central Parkway, Suite 1016, Altamonte Springs, Florida 32714-2545.

13. Defendant **Greg McCarthy** was an Area Manager for Defendant Lincare and can be served with process at 1937 U.S. 19 North, Suite 500, Clearwater, Florida 33764.

14. Defendant **Mark Tobin** is the Area Manager for Defendant Lincare and can be served with process at 1937 U.S. 19 North, Suite 500, Clearwater, Florida 33764.

15. Defendant **Lynn Garapic** is a Sales Representative for Defendant Lincare and can be served with process at 1937 U.S. 19 North, Suite 500, Clearwater, Florida 33764.

16. Defendant **Ron Pluchel** is a Center Manager for Defendant Lincare the offices for which are located at 224 W. Central Parkway, Suite 1016, Altamonte Springs, Florida 32714-2545.

17. Defendant **American Home Patient, Inc.** is incorporated in the State of Tennessee with its principal place of business at 5200, Maryland Way, Suite 400, Brentwood, Tennessee 37027. Its registered agent for service of process is Joseph F. Furlong, III, at 5200 Maryland Way, Suite 400, Brentwood, Tennessee.

18. Defendant **Rotech, Inc.** is incorporated in the State of Florida with its principal place of business at 4506 L.B. McCloud, Orlando, Florida 32811. Its registered agent for service of process is Usher Bryn, Esq., 2875 N.E. 190 First Street, Suite 802, Aventura, Florida 33180.

REFERRING PHYSICIAN DEFENDANTS

19. Defendant **Romeo G. Guzman, M.D.** is a medical practitioner and can be served with process at 1910 North Avenue, Orlando, Florida 32804.

20. Defendant **R. G. Guzman, M.D., P.A. Family and Geriatric Medical Clinic** is a professional medical corporation formed under Florida law and can be served with process at 1910 North Avenue, Orlando, Florida 32804.

21. Defendant **Alan Varraux, M.D.** is a pulmonologist medical practitioner and can be served with process at Associates of Pulmny & Crtl. Cre Med, 60 West Columbia Street, Suite F, Orlando, Florida 32856.

22. Defendant **Winter Park Internal Medicine, M.D., P.A.** is a professional medical corporation formed

under Florida law and can be served with process at 1855 Hollywood Avenue, Winter Park, Florida 32789.

23. Defendant **Ivan Castro** is a medical practitioner and can be served with process at and can be served with process at [sic] 1855 Hollywood Avenue, Winter Park, Florida 32789.

24. Defendant **Tolliver L. Higgins** is a medical practitioner and can be served with process at 1855 Hollywood Avenue, Winter Park, Florida 32789.

25. Defendant **John Daniel Mancini** is a medical practitioner and can be served with process at 1855 Hollywood Avenue, Winter Park, Florida 32789.

26. Realtor Kirk S. Corsello is also pursuing claims for relief against Defendants listed as John Does and John Doe Corporations 1-99 because, while they have been or are participating with the specific Defendants named in this Amended Complaint in presenting or causing to be presented false or fraudulent claims to the United States, their names or the complete facts concerning their complicity are presently are not known to Relator Kirk S. Corsello. In general the John Doe Defendants are present or former employees of certain DME Defendants or Referring Physicians. However, the John Doe Defendants also include other Referring Physician Defendants or owners or employees whose companies have been purchased by or joint ventured with certain DME Defendants. There may be more than 99 such John Doe Defendants just in the category of Referring Physician Defendants. However, that information is held primarily by the DME Defendants and the John Doe Defendants.

STATEMENT OF FACTS

THE MEDICARE MEDICAID PROGRAMS

27. Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.*, establishes the Health Insurance for the Aged and Disabled Program, popularly known as the Medicare program. The Secretary of HHS administers the Medicare Program through HCFA, a component of HHS.

28. The Medicare program is comprised of two parts. Part A provides basic insurance for the costs of hospitalization and post-hospitalization care. 42 U.S.C. §§ 1395c-1395i-2 (1992).

29. Part B is a federally subsidized, voluntary insurance program that covers a percentage (typically eighty percent) of the fee schedule amount for physician and laboratory services. 42 U. S.C. §§ 1395k, 1395l, 1395x(s). Reimbursement for Medicare claims are made by the United States through HCFA. HCFA, in turn, contracts with private insurance carriers to administer and pay Part B claims from the Medicare Trust Fund. 42 U.S.C. § 1395u. In this capacity, the carriers act on behalf of HCFA. 42 C.F.R. § 421.5(b) (1994).

30. Medicaid is a federally assisted grant program for the States. Medicaid enables the States to provide medical assistance and related services to needy individuals. HCFA administers Medicaid on the federal level. Within broad federal rules, however, each state decides who is eligible for Medicaid, the services covered, payment levels for services and administrative and operation procedures. The state directly pays physicians, with the state obtaining the federal share of the payment from accounts, which draw on funds of the United States Treasury. 42

C.F.R. §§ 430.0-430.30 (1994). The Federal share of each States Medicaid program varies state by state.

31. At all times relevant to this Complaint, the United States provided funds to the States through the Medicaid program, pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* Enrolled providers of medical services to Medicaid recipients are eligible for reimbursement for covered medical services under the provisions of Title XIX of the 1965 Amendments to the Federal Social Security Act. By becoming a participating provider in Medicaid, enrolled providers agree to abide by the rules, regulations, policies and procedures governing reimbursement, and to keep and allow access to records and information as required by Medicaid. In order to receive Medicaid funds, enrolled providers, together with authorized agents, employees, and contractors, are required to abide by all the provisions of the Social Security Act, the regulations promulgated under the Act, and all applicable policies and procedures issued by the State.

32. Among the rules and regulations which enrolled providers agree to follow are to: (1) bill the DMA or DMERC for only those covered services which are medically necessary; (2) neither bill the DMA or DMERC for any services or items which were not performed or delivered in accordance with all applicable policies nor submit false or inaccurate information to the Department relating to provider costs or services; (3) not engage in any act or omission that constitutes or results in over utilization of services; (4) not engage in any activity such as obtaining a list of Medicaid eligibles or canvassing neighborhoods for direct contact with Medicaid eligibles, or the payment of a referral or other fee which is not in compensation for medical care rendered to the recipient; (5) be fully licensed and/or certified under

the applicable state and federal laws to perform the services provided to recipients; (6) comply with state and federal statutes, policies and regulations applicable to the Medicaid Program; (7) not engage in any illegal activities related to the furnishing of services to recipients.

33. At all times relevant to this Complaint, the DME Defendants were participating Medicare Part B providers. The DME Defendants submitted claims to Medicare for services and durable medical equipment.

34. At all times relevant to this Complaint, the Medicare and Medicaid programs constituted a significant source of gross patient revenue for the DME Defendants.

SUBMISSION OF FALSE CLAIMS

35. Defendants **Lincare, Inc,, Lincare Holdings, Inc., Lincare Healthcare Group, Inc., John P. Byrnes, Lori Demello, Shawn Schabel, Larry Simmons, Greg McCarthy, Mark Tobin, Lynn Garapic**, and **Ron Pluchel** are collectively referred to as "**Lincare**" Defendants.

36. Defendants **Lincare, American Home Patient, Inc., Rotech, Inc.,** are referred to as "**DME**" Defendants.

37. Defendants **Romeo G. Guzman, M.D., R. G. Guzman, M.D., P.A. Family and Geriatric Medicine, Alan Varraux, M.D., Winter Park Internal Medicine, M.D., P.A., Ivan Castro, Tolliver L. Higgins, Daniel Mancini,** and many **John Doe and John Doe Corporations 1-99** are referred to as "Referring Physician" Defendants.

38. Lincare Defendants and other DME Defendants have pursued a scheme to defraud the United States by engaging in extensive kickbacks to Referring Physician Defendants as an inducement for Referring Physician Defendants to refer patients, including Medicare and Medicaid patients, requiring durable medical equipment and home health services to Lincare and other DME Defendants.

39. Certain of the DME Defendants camouflaged some of the kickbacks with contractual arrangements with certain Referring Physician Defendants including varieties of "consulting arrangements" or other programs intended to pay Referring Defendant Physicians for duties already owed to shared patients by virtue of the physician/patient relationship. The actual and primary purpose of these arrangements was to ensure that the Referring Physician Defendants referred patients to the specific DME Defendant with whom the Referring Physician had a contractual relationship. While this was an effective method for obtaining referrals, certain of the Referring Physician Defendants would have kickbacks from various DME Defendants. Accordingly, certain DME Defendants would closely track the value of their kickback arrangements with Referring Physician Defendants to determine whether the level of patients referred justified the kickbacks. Appropriate adjustments were then made.

40. The kickback schemes did not only encompass direct payments for referrals. Certain of the DME Defendants camouflaged some of the kickbacks in lease arrangements with certain of the Referring Physician Defendants. Sometimes DME Defendants would lease space from a Referring Physician Defendant and sometimes DME Defendants would lease space to Referring Physician Defendants. In either case,

the lease was secondary to the purpose of hiding the kickback.

41. Certain of the DME Defendants camouflaged some of the kickbacks in the provision of free or extremely reduced prices on equipment for certain of the Referring Physician Defendants or their patients. This included any of the durable medical equipment sold by the DME Defendants as well as monitoring devices such as oximeters.

42. One of the more disturbing practices involving kickbacks was the DME Defendants' provision of services for the Referring Physician Defendants while allowing the Referring Physician Defendants to bill Medicare for the services. For certain DME Defendants and certain Referring Physician Defendants this common practice included, *inter alia* services such as pulmonary function testing, pulse oximetry testing, spiromitry, heart monitoring and titrations. Certain DME Defendants provided discharge services for certain Defendant Hospitals for free with the requisite ability to refer a greater number of patients to the DME Defendant providing the service.

43. Certain DME Defendants provided medicine and equipment to Referring Physician Defendants who in turn could give them to patients. This includes, but is not limited to oximeters, oxygen, nebulizers, and medications.

44. Certain of the DME Defendants camouflaged some of the kickbacks in the form of free goods or benefits to certain Referring Physician Defendants' patients. Among other things this included the waiver of the mandatory 20% co-payment for Medicare patients. Certain of the DME Defendants would often "comp"

it or make it complimentary in order to induce referrals.

45. Another of the more disturbing practices involving kickbacks concerns the illegal storage and dispersal of medications by certain DME Defendants. When certain DME Defendants' drivers visited the home of a patient who had too much medicine the driver would occasionally pick up the medicine and bring it back to the office for storage. Then when certain DME Defendants wanted to induce referrals from certain Referring Physician Defendants, they would take from this store of illegal medicines to provide to that Referring Physician Defendants' patient on an emergency basis or as a "starter dose".

46. Certain Referring Physician Defendants would not only refer patients for kickbacks, but would also prescribe unnecessary or more costly durable medical equipment, medications, or services to allow certain DME Defendants to improperly charge Medicare the unnecessary costs. For example, certain medications allowed DME Defendants to make twice the profit of other medications. Another example is uncapped durable medical equipment or changing the prescription for durable medical equipment before the cap period is reached in order to allow for a longer billing cycle.

47. All Defendants conspired in these and other ways to cost the United States Government more money for improper or unnecessary goods and services. Like tax evaders looking for a loophole, certain DME Defendants pushed their employees to stay one step ahead of Medicare enforcement personnel by pushing different durable medical equipment, medicine, or services on Medicare patients.

48. Indeed, certain DME Defendants trolled for Medicare patients in order to "qualify" them for more costly or profitable services. Certain DME Defendants would send refills of medicines for patients who already had too much medicine in order that the DME Defendant could bill Medicare. Often this was done under the guise of "compliance" with physician orders when in reality it was a measure to push the profitability of the Medicare program for the DME Defendant to a maximum efficiency. Certain DME Defendants would be allowed unfettered access to certain Referring Physician Defendants' patient records. In the records, certain DME Defendants would find patients who were not yet prescribed all of the most profitable medicines, equipment, or services available this "oversight" would immediately be rectified by the DME Defendant.

49. Certain DME Defendants would troll their own patient lists to make sure that every Medicare patient had every allowable service, medicine, and piece of equipment that any other similar patient was allowed regardless of whether or not the physician had prescribed it. Certain DME Defendants would bill Medicare for changes in patient's requirements without ever having the patient see the treating physician.

50. Certain DME Defendants "lost" patients because the patients no longer met the Medicare requirements. These Defendants continued to troll those patients making every effort to "re-qualify" them.

51. Certain DME Defendants attempted to get lists of Medicare patients from various physicians by proposing to teach patients how to use certain durable medical equipment, such as an inhaler, for free.

52. For a variety of reasons, certain DME Defendants have engaged in a pattern and practice of receiving signed, but otherwise blank, certificates of medical necessity from certain of the Referring Physician Defendants and using DME Defendants' staff to complete portions of the certificates only a physician or staff member is authorized to complete. Certain DME Defendants have engaged in a pattern and practice of forging information on prescriptions including, but not limited to, the physician's signature. With certain DME Defendants this practice was so prevalent that certain employees insisted on stockpiling a variety of different colored and styled pens to assist in forging prescriptions and defrauding Medicare. One or more of the DME Defendants has even given this practice the code name of "Doctor Papsmear". This is done in violation of 42 U.S.C. § 1395m(j)(2)(A)(iii) and/or 42 U.S.C. §1320a-7a(l). The Referring Physician Defendants, by providing signed but otherwise blank certificates of medical necessity, have knowingly caused and continue to cause false and fraudulent claims to be submitted to the United States by DME Defendants, in violation of 31 U.S.C. § 3729. By this practice, certain DME Defendants have billed Medicare for unauthorized medicine, equipment, and services.

53. Certain DME Defendants and Referring Physician Defendants conspired to leave parts of the prescriptions blank so that the DME Defendants could make changes to the physician's orders such as a change to or from liquid oxygen.

54. Certain DME Defendants have engaged in a pattern and practice of manipulation to attempt to get potential patients to qualify for goods or services. For example, certain drivers have been known to walk patients to and from the mailbox several times if the initial oximetry reading was not low enough. The

falsification of prescriptions and other identifications of needs also falls into this category. Employees of certain DME Defendants will order medicines without the patients permission because it is a pattern and practice, and because incentive programs are set up to reward such employees for increased use of medications.

55. Certain Referring Physician Defendants were looking for any additional money. Certain DME Defendants tried to assist Referring Physician Defendants in using different codes to get more money from Medicare.

56. Certain DME Defendants have also provided medical equipment for their patients prior to obtaining, or entirely without the proper, prescriptions or other documentation. Certain medicines and equipment have also been provided to patients for free in order to show certain Referring Physician Defendants that the medicine and/or equipment is needed. Certain DME Defendants would also recover equipment from patients who have passed on and re-rent the equipment even if the patient had purchased the equipment or it had been "capped out".

57. One result from many of the schemes perpetuated on the Medicare program is that patient care depends on the profitability under Medicare reimbursement of the products or services rather than what is important for proper patient care. As an example, one or more DME Defendants provided ultrasonic nebulizers because they thought they were "uncapped items" under the Medicare guidelines; however, when the DME Defendants learned that the ultrasonic nebulizers were not reimbursable, all patients were swapped out for "billable services". Also, certain DME Defendants sought out Referring Physician Defendants to change medications for patients

because the profitability of some medications was higher than others under the Medicare guidelines. Certain DME Defendants also failed to provide good service in order to save money. For example certain DME Defendants failed and refused to check equipment such as concentrators. Certain DME Defendants also submitted bills to Medicare after patients no longer required service including after the death of the patient.

58. Kirk S. Corsello was previously employed by Defendant Lincare as a center manager in Orlando.

59. In his capacity as a center manager, Mr. Corsello became aware of specific fraudulent acts involving Defendant Lincare.

60. In addition, Mr. Corsello learned facts indicating that Defendant Lincare was involved in other fraudulent activities also involving the other Defendants.

61. Mr. Corsello investigated the fraud, made reports of the fraud, and threatened to bring the fraud to public scrutiny.

62. Mr. Corsello was threatened and believed himself to be in personal danger for his investigations, discoveries, and threatened exposure.

63. Defendant Lincare discharged Kirk S. Corsello from his position as branch manager in violation of 31 U.S.C. § 3730(h).

64. Kirk S. Corsello was also employed by Defendant Rotech.

65. Defendant Rotech also discharged Mr. Corsello in violation of 31 U.S.C. § 3730(h).

LINCARE DEFENDANTS

66. Lincare Defendants have engaged generally in all of the illicit behavior illustrated above.

67. Between 1985 and 1989 and upon belief from 1989 to the present, Lynn Garapic was involved in and supervised the filling in of CMNs, the fabrication of information on CMNs to qualify patients, and the forging of doctors' signatures on oxygen CMNs by Lincare employees.

68. From before 1984 through his employment with Lincare which ended in late 1997 Larry Simmons was involved in and supervised the filling in of CMNs, the fabrication of information on CMNs to qualify patients, and the forging of doctors' signatures on oxygen CMNs by Lincare employees. One of the doctor's signatures that Larry Simmons knew was often forged was Dr. Sheiman from West Palm Beach, Florida.

69. From before 1984 through 1997 and, upon belief, to the present, John Byrnes was involved in and supervised the filling in of CMNs, the fabrication of information on CMNs to qualify patients, and the forging of doctors' signatures on oxygen CMNs by Lincare employees. One of the doctor's signatures that John Byrnes knew was often forged was Dr. Sheiman from West Palm Beach, Florida. Indeed, John Byrnes documented one instance of his own completion of CMNs via request to Tommy Titshaw a Lincare employee in West Palm Beach, Florida. In fact, on more than one occasion, John Byrnes has commanded Lincare employees that if they could not get a CMN signed they were to bring them to him and he would sign them. During this same time frame, John Byrnes also specifically said to more than one Lincare employee that if they could not get a CMN signed he would send it to a doctor in West Palm Beach who would sign any other doctor's CMN.

70. In at least 1997, Greg McCarthy was involved in and supervised the filling in of CMNs, the fabrication of information on CMNs to qualify patients, and the forging of doctors' signatures on oxygen CMNs by Lincare employees. Greg McCarthy was also responsible for terminating Kirk Corsello's employement in violation of 31 U.S.C. § 3730(h).

71. From at least 1990 through 1997, Ron Pluchel was involved in and supervised the filling in of CMNs, the fabrication of information on CMNs to qualify patients, and the forging of doctors' signatures on oxygen CMNs by Lincare employees.

72. According to statements made by Larry Simmons, Lori Demello, while a Center Manager with Lincare, was illegally sending monthly refills without knowing whether they were needed. Of course, not all patients would take all their medicine all the time. The alleged purpose of the compliance program was to see that the patient was taking his or her medications and oxygen as prescribed. In reality, Lincare simply tried to push the medications to up its profits. Some Center Managers, like Lori Demello, would send the medicine regardless of whether the patients were using it or not. In that way, it appeared that she had nearly 100% compliance. UD compliance knew by the report how many units went out by tracking the prescriptions versus actual orders. Lori's unit was 100% compliant which was a practical impossiblity. Also from at least 1996-1997 and upon belief to the present, Lori Demello was involved in and supervised the filling in of CMNs, the fabrication of information on CMNs to qualify patients, and the forging of doctors' signatures on oxygen CMNs by Lincare employees.

73. Shawn Schabel was the regional vice president over Larry Simmons area. He was aware of, approved of, and encouraged the improper actions of Lincare employees in his area as described above and below.

74. From at least 1995 through 1999, Mark Tobin was involved in and supervised the filling in of CMNs, the fabrication of information on CMNs to qualify patients, and the forging of doctors' signatures on oxygen CMNs by Lincare employees.

75. All of the general allegations of the Amended Complaint apply specifically to Lincare.

76. As a handful of examples of CMNs used to support DME and oxygen, but filled in by Lincare employees, Mr. Corsello presents the following; Helen Burgess dated 1/9/97; Robert Purvis dated 7/9/98; Reita Trench dated 12/27/94 (Leslie Caldwell); Rita Trench dated 2/12/96 (Dennis McNamee); Viola Stewart dated 9/30/97 (Mark Cyman); Viola Stewart dated 6/22/95 (Jennifer Wagner); Genie Stewart dated 12/17/96 (Mark Cyman); Hilda Montalvo dated 7-18-97 (Mark Cyman).

77. Similar incidents of filling in of CMNs, the fabrication of information on CMNs to qualify patients, and the forging of doctors' signatures on oxygen CMNs by Lincare employees occurred in the Altamonte Springs center from at least 1985-1989, the West Palm Beach center from at least 1989-1993, the Vero Beach center and the Ochecobee center from at least 1993-1997, and the West Palm Beach center from 1989-1993.

78. The CMN issues are nationwide and identical problems exist in every geographic area in the Lincare companies. The Lincare employees who review the CMNs are told to assume that everything is coming from the doctor even though it is obvious it is not. In some areas of Lincare 25 to 50% of the CMNs submitted are illegal or improper and in other areas it is a higher percentage. It is also a frequent practice to see a sample CMN or post it notes attached to a CMN telling the doctor how to fill it out when the

CMNs are sent to Lincare's billing department. The billing department is told to disregard these things and bill Medicare anyway.

79. Lincare's management tracked held sales in each of its offices. Held sales were created when a CMN was not submitted or submitted without being completed. Lincare's management knew that the only way to decrease the held sales to the extent it required, Lincare's employees would have to complete the CMNs themselves and possibly sign doctors names to the CMNs. Rather than clean up the practice, Lincare management encouraged the practice. All of Lincare management knew about the CMN fraud and abuse.

80. Under the management of John Byrnes and Shawn Schabel, while others in the industry were growing at 15% per year, some of the Lincare centers were growing at 45-60% per year. This was due in part or in whole to Lincare's policies and procedures encouraging or demanding Medicare fraud and abuse. The low held sales in high volume areas, the high compliance in high volume areas, and the extraordinary growth rates in several areas are clear indications to people in the industry that Lincare is engaged in fraud. Any high volume area that meets the requirements for medicine compliance or held sales is engaged in Medicare fraud and abuse. Lincare management also sets standards by geographic comparisons. If one center's held sales is the lowest in the country the employees are rewarded and all other centers are held to that standard. This has caused unrealistic numbers to become the standard at Lincare causing Lincare employees to commit fraud to keep up with other centers who are committing fraud.

81. It is also not unusual for a patient to be tested by Lincare employees at exercise, but provided portable and stationary units and vice-versa.

82. Between 1984 and 1996, Lincare entered into relationships with doctors who insisted that they would not refer patients unless Lincare employees filled out the CMNs for the doctor.

83. Shawn Schabel adopted and promoted the Lincare philosophy of Medicare fraud and abuse and if any of the employees under his supervision were unwilling to follow that philosophy, Mr. Schabel let them know that their jobs were in jeopardy. Mr. Mark Tobin would do likewise.

84. Lincare therapists self qualify patients. One remarked to an area manager that he could "qualify a houseplant." In Lakeland, Florida between 1984 and 1996, Lincare employees self qualified patients.

85. It is unrealistic to have 50% compliance with respiratory medicines. However, the pressure from Lincare to its employees is to have close to 100% compliance. The employees know that the only way to meet the requirements is to send medicine when it is not needed.

86. Lincare's unwritten policy was that every center was to keep some respiratory medicines on site. Almost every Lincare center illegally stored these medicines in their building. These stored medicines were provided to future Lincare patients.

87. Lincare had incentive programs for its drivers and other employees to try to get its Medicare patients on as many reimbursable items as possible. Lincare drivers would actually talk patients into getting their doctor to prescribe medicines for them.

88. Lincare would rent office space to or from doctors at above or below market value in an attempt to induce referrals. Lincare would also give equipment to doctors for free or at reduced rates to induce referrals.

One example is with Dr. Mederos. Lincare rented Dr. Mederos equipment at below market rates and he would bill Medicare for the full services. If Medicare would allow $100 for a hospital bed, Dr. Mederos would have him order 100 hospital beds and Lincare would charge him $50 for the bed.

89. Lynn Garapic was instrumental in getting Dr. Varraux on with Lincare. Dr. Varraux was one of the top referral sources in Larry Simmons area. Dr. Varraux received more money from Lincare than any other doctor.

90. While Medicare does not often cover the costs of medicines. If Lincare could troll its own patients and convert them to a breathing treatment, the [sic] found they could make money from Medicare without really providing a service to the patient. Accordingly, it was Lincare's policy to search out their own Medicare patient lists and convert all patients to breathing treatments and medicine. There were incentives provided to drivers and other employees for such conversions.

91. John Byrnes completed CMNs himself while in the Tallahassee office where CMNs were not completed.

92. It is Lincare's pattern and practice to appear to the outside world to be attempting to comply with Medicare guidelines. Indeed, Lincare management will often send memos and other documents around concerning such compliance. However, the oral countermands are the real policy of Lincare. Lincare's management makes it clear that if employees do not push their ethics to the limit and bend or break Medicare guidelines, the employees will no longer be employed with Lincare.

93. John Byrnes executed Medical Director agreements regularly. The Lincare policy was to pay doctors

based on a formula concerned only with potential referrals.

94. It has been Lincare's policy to put their patients on as many Medicare items as possible. Lincare has several programs that are designed to do just that. Generally, the program will start with a chart evaluating Lincare's current Medicare patients and what they do not yet receive. Then incentives are provided to push all possible equipment and medicine on them regardless of need or usage. The progress for many Lincare patients is from oxygen to nebulizer to medicines to Bi-pap to Bi-pap ST. The Bi-pap ST and other items are pushed by Lincare because they are uncapped items under Medicare regardless of patient need.

95. Certain Lincare centers and areas were instructed between 1988 and the present to obtain several different colored pens and several different typewriter balls so that the Lincare employees could fill out the CMNs without detection.

96. When John Byrnes was in Mobile, Alabama, he would bill Medicare for a full refill of oxygen regardless of how much oxygen it really took to refill the patients tanks. He instructed those under him to do the same. Once when a center manager from Tallahassee caught an employee from Tampa filling out a CMN she laughed and responded "I'm just doing what John Byrnes has told me to do and if you have a problem with that, you need to talk with him."

97. At Lincare, when the regional accounting office would send back CMNs Lincare employees would mark them up with fictitious initials to indicate the changes were made by a physician or a nurse.

98. Lincare has changed dates on CMNs to allow for billing before the qualifying tests were done.

99. The Neptune City Lincare center has an arrangement with the local hospital wherein the hospital will order DME from Lincare and receive a 30% kickback. This was occurring as late as March 1999.

100. After receiving notice of this lawsuit and of a possible government investigation, Lincare has sent at least two written directives to its employees to avoid cooperating with the government investigators.

101. Lincare, Inc. and Lincare Holdings, Inc. are vicariously liable for the actions of their subsidiaries, divisions, employees, officers, and directors.

ROTECH DEFENDANTS

102. Upon information and belief, Defendant Rotech has engaged in most or all of the illicit behavior illustrated above.

103. According to a statement made by Larry Simmons, a co-conspirator with Defendant Lincare, in the mid 1990s, Lincare was considering purchasing a DME company in Miami, Florida that had approximately 110 oxygen patients. This company did not have CMNs for any of its patients on oxygen, and Lincare was concerned about purchasing a company that did not have CMNs on file. While Lincare requested of the DME company owner to obtain CMNs, Rotech simply purchased the company as a going concern.

104. In February 1996, Rotech purchased Duracare Medical. Soon after the purchase, C.D. Gunselman and Chele Dallas, among other employees of Rotech, adjusted old accounts to cover up the losses. Then Rotech transferred inventory between stores in Arkansas, but did not make accounting adjustments. After Rotech took over the operation of Duracare, Rotech changed several policies and procedures.

These included, but are not limited to, the requirement of setting up sleep labs for doctors at no cost to the doctors or other referral sources. One example involved Walter Lumpkin and Wendy Baker. Walter Lumpkin was instructed by Rotech to create a sleep lab for Wendy Baker in Northwest Arkansas. Rotech picked up a large amount of Wendy Baker's expenses in general. For example, Melissa Walker, Rotech's regional respiratory director, helped furnish an office for Baker and turned in all the expenses to Rotech.

105. Upon information and belief, Rotech has billed Medicare for nursing home patients in Oklahoma that did not even exist. Upon information and belief, Dan James, a regional manager for Rotech was involved in this matter.

70 [sic]. After February 1996, in Arkansas, and believed to be nationwide, Rotech provided bonuses to its respiratory therapists who could put existing patients on nebulizers with medicines. The bonuses were based on the additional monies that could be billed to Medicare for the existing patients. Respiratory Therapists were told that all patients should be on nebulizers, and all nebulizer patients should be on all available nebulizer medicines. Indeed, part of the bonus was specifically based on getting the additional medicines, if the patients were already being prescribed some medicines. The push from Rotech was not that the patients really needed any of these things, but rather that Rotech could make more money. With the medicine especially, Rotech did not need to provide a service because the medicines were shipped directly from the pharmacy. At the same time, Rotech pushed its "drivers" to get patients to switch DME companies or to get additional medicines. The drivers were paid a bonus for these activities, which bonuses were coordinated

through Melissa Walker at the end of each month. In fact, Rotech produced a chart each month tracking these activities.

71 [sic]. After February 1996, Rotech management in the Arkansas area, and believed to be around the country, pushed its employees to go through the lists of current patients and engaged the patients to get as much DME and medicine as they could. One item that was particularly important to Rotech was the Bi-PAP ST. Rotech management indicated that it wanted every patient on the Bi-PAP ST whether they "needed" it or not, and regardless of whether it benefited the patient. Employees were told that it gets revenue up.

72 [sic]. After January 1988, Rotech and Integrated Health Services, Inc., its parent company, came up with a method of trolling for Medicare patients. Rotech and IHS used a form in Missouri, and upon belief in other parts of the country, to determine which patients are Medicare patients, and of those which can possibly be "qualified" for oxygen by Rotech employees.

73 [sic]. As recently as June 14, 1999, Rotech employees, including Melissa Walker and Stacy Cline, offered potential referring physicians in Arkansas that they would "screen" the patients' charts to determine what patients needed to have PFTs done, perform PFTs on those patients, and rent the doctors a titration machine for below market value. The purpose of these offers was to induce referrals from the physicians.

74 [sic]. From before December 1989 through the present, an entity that was purchased by Rotech in 1994 has consistently committed fraud on the Medicare program. Rotech and its employees have

known about it from before the purchase and have continued or increased the practices from 1994 to the present.

75 [sic]. In the Dothan, Alabama branch from at least 1989 to the present, Rotech charged Medicare for new equipment which was actually used. Some examples include: Mildred Hicks on 2/22/99; Katie Hudspeth on 2/28/99; Edgar Hughes on 2/27/99; Robbie Jackson on 2/27/99; and L. V. Jenkins, Sr. on 2/20/99. Rotech also billed patients improperly. Glenda Howard was one of the Rotech supervisors who instructed others to improperly bill. Oddly, Glenda and others would have patients improperly billed for monies Rotech had no ability to collect, but would not try to collect the co-pay obligation for Medicare. Rotech routinely "wrote off" the co-pay amount with only one and sometimes no attempts to collect. Some of the patients who were billed improperly were J. C. Ward in 1998 (July-December); Louise Dude in 1998-1999; Ollie M. Messer in 1999 (January-March); and Rosie Minniefield in 1998-1999.

76 [sic]. In the Dothan, Alabama branch from at least 1989 to the present, Rotech employees were told to change the data or codes on certificates of medical necessity. A Rotech supervisor, Steve Griggs, oversaw the process and was aware of the changing of data and codes. The manager of the branch would routinely fill in portions of CMNs that were received by Rotech and filled out incompletely. It was considered "routine practice" to fill in CMNs. In fact, on many occasions, the billing clerk would provide the Rotech manager with unsigned CMNs and would receive forged CMNs forged by the manager. Most of the CMNs at the Dothan branch were incomplete in

some respect when they were received from doctors. These CMNs were completed by the billing manager. Some CMNs were completed by other Rotech employees. The CMNs from the Dothan branch would routinely be signed in different colored inks and have handwriting different from the doctors. It was routine for the CMN to contain handwriting that did not match the doctor's signature or diagnosis code. A comparison of doctor's signatures on CMNs also indicates that the doctors' signatures varied on many CMNs. Some examples of CMNs filled out by Rotech employees include one for Andrwe [sic] Geofrey dated 3/2/99; Mattie May dated 1/7/99 (revised 3/7/99); Willie Hayes dated 12/11/98; Alice Money dated 2/19/99; and Dorthy Luckic dated 1/22/99.

77 [sic]. In the Dothan, Alabama branch after Medicare made it clear that doctors were not to be instructed on how to fill out a CMN. Rotech wrote letters to doctors doing just that. One example is a document called "WRITTEN CONFIRMATION OF VERBAL ORDER". These were sent to the doctors with the CMN in order to help the doctor fill in the CMN. In the Dothan, Alabama branch from at least 1989 to the present, Rotech routinely billed Medicare for supplies not required by doctor's order. The pattern and practice was that with certain DME equipment other equipment or disposables would be provided and billed to Medicare. Once a doctor actually complained. Dr. O'Brien called Rotech because he had ordered a hospital bed and Rotech had added a pressure pad and pump. When Rotech sent the certification to the doctor they added the extra equipment. The doctor was upset because he knew he had not authorized the extra eq ipment, and although he said he would sign it this time, they

were not to put anything extra on his patients' orders in the future.

78 [sic]. In the Dothan, Alabama branch from at least 1989 to the present, Oxygen patients are always maximized. Rotech routinely added portability to CMNs. It was Rotech's intention to put a portable oxygen tank into every house were oxygen was ordered whether the doctor ordered portability or not.

79 [sic]. In the Dothan, Alabama branch from at least 1989 to the present, Rotech would pick up beds after patients died and rent them again as new equipment. Rotech has a warehouse of old beds used to fill orders. Rotech does not have matching invoices for the beds provided as new.

80 [sic]. In the Dothan, Alabama branch from at least 1989 to the present, Rotech pushed electric wheelchairs because they are a high profit item. Rotech billed Medicare for electric wheelchairs without proper doctor certification. Two examples were the wheelchairs provided to Wiliam Shoelos and Loyd Dixon in March of 1999. It has consistently been Rotech's policy to push its employees to make more profit per patient no matter how it is done.

81 [sic]. In the Dothan, Alabama branch and upon belief around the country, Rotech pushed its employees to put all possible patients on Bi-PAP ST, regardless of need. The basis for the policy is that this item is uncapped by Medicare and it is very profitable.

82 [sic]. In the Dothan, Alabama branch from at least 1989 to at least 1998, Rotech would routinely order refill medicines for its patients without even checking with the patients concerning their compliance.

These orders were made whether or not the patient actually needed the additional medicine and whether or not the medicine was properly being used by the patient. Suddenly, about one year ago, Rotech employees were instructed to call the patients about respiratory medicines. However, the policy and practice never changed for diabetic supplies.

83 [sic]. Harvey Mosley was a patient of Rotech. He sent back some durable medical equipment, but Rotech continued to bill Medicare for the items. Harvy [sic] Mosley sent back his durable medical equipment around July 2, 1998 and was billed for it until he died. The whole time Rotech was billing for the durable medical equipment, Harvy [sic] Mosley had been using durable medical equipment from a different company. Iris June Delaney got a standard wheelchair in May 1998 and went into a nursing home five months later. Rotech continued to bill Medicare and received payments from Medicare while Ms. Delaney was in the nursing home. When one of the employees of Rotech complained about these matters, she was immediately fired.

84 [sic]. Rotech would charge Medicare more than it would charge private patients. For example, in Dothan, Alabama, Rotech charged a private insurance company $299 for a breast prosthesis and bras, but charged Medicare $314.

85 [sic]. Rotech in South Carolina and, upon belief, the rest of the country, was engaged in the Medicare fraud and abuse generally described above. For example, Rotech called its "nonventilatory" program the NPPV program. Rotech in South Carolina and, upon belief, the rest of the county, designated an employee as the NPPV "Coordinator". The job of

the "Coordinator" was to search through Rotech patient files and find patients to put on the NPPV program. On August 10, 1998, the NPPV Coordinator for South Carolina was performing this responsibility at the Rotech Surfside Beach branch.

86 [sic]. Mike Loftis and Fred Willis, management for Rotech, have held out Anthony Succo as a marketing person that Rotech would like to "clone". Anthony Succo was an area manager for Rotech in 1998. On August 11, 1998, Anthony Succo went to Dr. Brian Adler's office and handed him a blank CMN. Anthony explained to the doctor that Anthony wished to put Mrs. Mildred Durgin on the NPPV program, and the doctor signed the blank CMN and gave it back to Anthony. On that same day, Anthony made the same pitch in the same way to Dr. John Rathburn with the same results ostensibly for Mrs. Melinda Durkee. When Anthony Succo returned from the doctors' offices, he had the Rotech customer service representative fill in the CMNs. The two patients "signed up" on August 11, 1998 were the results of a process adopted by Rotech in South Carolina and, upon belief, the rest of the country. The program was that the NPPV Coordinator would go through the patient files and identify the patients who were NPPV "candidates". These names were then turned over to someone like Anthony Succo who got the doctors to sign blank CMNs which were then filled out by Rotech staff.

87 [sic]. On August 12-14, 1998, Anthony Succo spoke with medical professionals in the Myrtle Beach area. Anthony told them that Rotech would "do the setups in the doctors offices and allow them to bill for it." During the presentation Anthony Succo mentioned other doctors who were already

allowing Rotech to perform these activities in their offices. One of these doctors mentioned works in Wilmington, North Carolina.

88 [sic]. On August 19, 1998 Fred Willis indicated that Steve Miller was exemplary in the Rotech program called Neb. & Meds or the Neb/Meds program. Steve Miller was from Rotech in Orlando, Florida, but at this time was training people in Monroe, North Carolina. Rotech's program that upon belief is nationwide consists of printing reports of Rotech patients who are on oxygen, but not on both Albuterol and Ipatropium who have Medicare as the primary payor. The Respiratory Therapist is instructed to pick out five patients from the list on a given day and visit them to try to get them on both medicines seperately [sic] in some form of unbundling. On August 19, 1998, Steve Miller and other Rotech employees were successful in "converting" all five patients seen in Monroe, North Carolina to both medicines.

89 [sic]. In September 1998, Tim Pigg was acknowledged as "another great marketer". Tim Pigg was also a Rotech area manager. On September 1, 1998, Tim Pigg was in the Rotech Lincolnton, North Carolina branch. Rotech, through Tim Pigg, had a special incentive program for obtaining Neb/Med patients with a sales representative in this branch by the name of Lisa Benson. On September 1, 1998, Lisa drove to Kings Mountain to see a doctor about getting a pad prescription for a patient who was on oxygen, but not medicines. Lisa started the explanation to the doctor, and he simply asked what she wanted him to put on the prescription. She asked for #1 hand held nebulizer; #2 Albuterol sulfate 0.83% or 2.5 mg; and #3 Ipatropium 0.02%. The doctor wrote the prescription and told Lisa that he has two patients

he just discharged that he wanted her to see. These patients were Mr. William Greene and Jet Parker. Lisa indicated that she would put them on the NPPV program. Later that day, Lisa acknowledged that she had gone so far as to fill out pad prescriptions for doctors and have them sign the prescriptions.

90 [sic]. Another Rotech employee, Patty Neil, was considered exemplary and had the largest base of patients on nebulizers and medicines in the 90-branch region. Patty was promoted to area manager. September 3, 1998, Patty Neil told Kirk Corsello that she would go into doctor's offices and do nebulizer treatments or Spirometry treatments and allow the doctors offices to bill for her services.

91 [sic]. On September 10, 1998 in Spartanburg, South Carolina, Rotech presented several Rotech programs to their area managers. One issue raised was getting the most Medicare money for each patient. Rotech had what they called the "Grigg's Grid". This was a grid showing how much more each Medicare patient could earn for the company if they were using every possible Medicare resource. For example, Rotech tracked the comparative analysis of numbers of patients on oxygen concentrators versus those who also had medicines. Another comparative analysis was oxygen patients versus those who were also part of the NPPV program. On September 10, 1998 in Spartanburg, South Carolina, Steve Miller did the comparative analysis. Later, another Rotech employee talked about the "wheelchair push". The program involved going through all of the patient lists for patients with light weight wheelchairs to see if they could be converted to power wheelchairs.

92 [sic]. On October 8, 1998, Suzanne Davis met with Kirk Corsello in Fitzgerald, Georgia. Suzanne had been promoted from customer service representative to center manager. Suzanne told Kirk that an ex-Rotech employee was taking all of Rotech's patients in that area. Suzanne told Kirk that Rotech's fraud in that area was so pervasive that Steven Griggs himself flew in a company plane to meet with this former employee. The former employee told Steve Griggs and the company attorney that if they "messed" with him he would call Medicare and tell them about all the fraud that Rotech was engaged in. Steve Griggs and Rotech backed off from the ex-employee, and he "converted" over fifteen of their patients to his new company. Those patients were worth around $200,000 per year. Suzanne was concerned that it would not reflect well on her productivity, but she knew there was nothing she could do. One of these patients was Mrs. Johnie Odum. Mike Loftis, Jim McNabb, and Debra Nessmith spoke to Kirk Corsello concerning these events. Debra Nessmith admitted that in this area of Georgia, Rotech employees "fixed" CMNs and self-qualified patients by smashing the pulse oximiter on the patients' fingers to get a lower reading.

93 [sic]. On October 20, 1998, Danny Jernigan and Gill McCall, known as rehabilitation specialists, were talking about marketing and success. At one point they bragged about how they paid $8,000 for a power wheelchair and got paid $32,000 from Medicare. They exemplified the attitude at Rotech that Medicare existed for Rotech to make as much profit as possible regardless of the merit or the consequences.

94 [sic]. Rotech, Inc. and its parent company are vicariously liable for the actions of their subsidiaries, divisions, employees, officers, and directors.

AMERICAN HOME PATIENT DEFENDANTS

95 [sic]. Upon information and belief, Defendant American Home Patient has engaged in most or all of the illicit behavior illustrated above.

96 [sic]. On or before January 1988 up through the present, AHP entered into Medical Director Agreements with referring physicians across the United States. The Medical Directors would get paid a monthly salary based solely on the expectation of referrals. Accordingly, the amounts would vary widely not dependant on any varying factor other than, the expectation of referrals. It was a clear AHP policy during most of this time period that the referring physicians did not have to perform any act in order to get paid for being "medical directors". However, when the United States government recently requested documents from various durable medical equipment companies in conjunction with its investigation of this lawsuit, AHP's lawyers started dictating that AHP employees should see if they could get the referring physicians to "do something" for the money.

97 [sic]. At the same time that AHP policy was changing concerning the Medical Director Agreements, it was changing about tracking equipment provided to potentially referring physicians for free or below market value. AHP lawyers and "higher ups" directed the managers and supervisors to "lose" the equipment on the inventory scrolls that AHP had given to doctors because the attorneys were

"nervous" about "loaner equipment" to doctors. Terry Bennett was one of the regional managers who attempted to carry out this directive as well as the one concerning Medical Director Agreements. Indeed, Terry Benett personally called all of his locations to tell them to "get rid" of the inventory sheet or to show that the doctor purchased the equipment. Upon information and belief, this was also done by Terry Bennett's colleagues nationwide.

98 [sic]. From before November 1995 through August 1997 and beyond, AHP used the Medicare provider number of Medical Home Supply to bill for patience serviced by Orange Park Medical Center. At the end of every month, an employee of AHP would meet with an accountant who would figure out the amount of money to be disbursed to Orange Park Medical Center from Medical Home Supply.

99 [sic]. American Home Patient, Inc. is vicariously liable for the actions of their subsidiaries, divisions, employees, officers, and directors.

REFERRING PHYSICIAN DEFENDANTS

100 [sic]. Referring Physician Defendants have been involved in many of the allegations involving kickback arrangements with Defendant Lincare.

101 [sic]. Romeo G. Guzman, M.D., and R. G. Guzman, M.D., P.A. Family and Geriatric Medicine received no fewer than four checks of $750 as an inducement for referrals. The check dates are as follows: 6/6/95, 10/31/95, 12/29/95, and 6/30/95. Around January 15, 1995, Lincare prepared a document entitled Respiratory Therapy Services Agreement which was executed by Jim Kelly of

Lincare and R.G. Guzman of R. G. Guzman, M.K. [sic], P.A. Family & Geriatric Medicine. The amount of the payments was set at $750 based on a Lincare formula that they expected 7 referrals per month at a value to Lincare of $50 per referral. When it was later determined that Dr. Guzman was not referring enough patients, the contract was terminated by Lincare. Dr. Guzman never performed any task for Lincare which would merit the checks he received. In fact, Dr. Romeo G. Guzman asked a sales representative (Jennifer Wagner) for his check. Kirk Corsello referred the matter to his supervisor Larry Simmons. Larry told Kirk to print out a referral trend report for 1995 and track Guzman's recitals. Larry and Jim Madison figured out that Dr. Guzman had the potential to send 5 to 7 Unit Dose (UD) referrals per month. Larry said it was worth about $50 a patient for the doctor provide nebulizers directly to his patients as opposed to Lincare rushing out to do it. The formula was as follows: 5-7/mo x 3 mos x $50 = $750/qtr. When Lincare reviewed the reports, they found out Dr. Guzman wasn't sending 5-7 a month, so they canceled his contract. However, Larry Simmons said he wanted someone else to fill the slot.

102 [sic]. John Daniel Mancini, Tolliver L. Higgins, Ivan Castro, and Winter Park Internal Medicine, M.D., P.A. were looking for a kickback arrangement with Lincare. On behalf of the practice, Dr. Mancini asked Kirk Corsello if Lincare "needed any Medical Directors." In addition, Mark Zayas, a Lincare employee, had several improper relationships with these Defendants. One example was the pulse oximiter purchased for Winter Park Internal Medicine by Lincare. When the software was loaded on the machine, Lincare

employees typed in the name Winter Park Internal Medicine so that Lincare could self-qualify patients and make it appear that the results were printed by Winter Park Internal Medicine. These Defendants were complicit in this self qualification. However, Lincare ran into problems in self qualifying other doctor's patients and would have to white out or cut off the top of the results page. In a Lincare Memo from Mark Zayas to Ron Pluchel dated April 8, 1997 concerning this software he wrote: "Please be aware that the program i [sic] loaded on Chris's [sic] laptop has winter park Internal medicine [sic] group on the top of each page when printed. please [sic] white out or cut off this portion of each page printed from the program as it would be embarrising [sic] if this got back to them."

103 [sic]. Dr. Alan Varraux has had an extensive relationship with Lincare dating back to before 1990. Dr. Varraux has an agreement with Lincare similar to that of Dr. Guzman, however, Dr. Varraux gets paid several thousand dollars per month. Pursuant to his relationship with Lincare, Dr. Varraux has unbundled the two respiratory medicines on his prescriptions allowing Lincare to bill more to Medicare. In addition, for the payments and other benefits of the relationship, Dr. Varraux refers his patients to Lincare.

COUNT I
FALSE CLAIMS ACT VIOLATIONS

104 [sic]. Relator hereby incorporates and re-alleges herein Paragraphs 1-103 as fully set forth herein.

105 [sic]. As set forth above, Defendants by and through their agents, officers and employees, presented,

caused to be presented, or conspired to present to an officer or employee of the United States numerous false or fraudulent claims for payment or approval, in violation of 31 U.S.C. § 3729(a)(1).

106 [sic]. The United States has been damaged as a result of Defendants' violations of the False Claim Act in an amount to be proven at trial. The United States is entitled to this sum as reimbursement for monies obtained by the Defendants for fraudulent claims submitted to the United States.

107 [sic]. The United States is entitled to treble damages based upon the amount of damage sustained by the United States as a result of Defendants' violations of 31 U.S.C. § 3729(a)(1)-(3).

108 [sic]. The United States is entitled to a civil penalty of between $5,000 and $10,000 as required by 31 U.S.C. § 3729(a) for each of Defendants' fraudulent claims.

109 [sic]. Relator is also entitled to reasonable attorney-fees and costs, pursuant to 31 U.S.C. § 3730(d)(1).

COUNT II
FALSE CLAIMS ACT RETALIATION VIOLATION
(DEFENDANT LINCARE)

110 [sic]. Relator Kirk S. Corsello hereby incorporates and re-alleges herein paragraphs 1 through 109 as if set forth fully herein.

111 [sic]. Defendant Lincare terminated Relator Corsello in express violation of 31 U.S.C. § 3730(h).

112 [sic]. Pursuant to this statute, Relator Corsello is entitled to be reinstated at the same level of seniority he would have enjoyed absent this termination; an award of two times the amount of back pay due plus interest; compensation for special damages; and litigation costs and reasonable attorney's fees.

113 [sic]. Relator Kirk S. Corsello is also entitled to reasonable attorney fees and costs, pursuant to 31 U.S.C. § 3730(d)(1).

COUNT III
FALSE CLAIMS ACT RETALIATION VIOLATION
(DEFENDANT ROTECH)

114 [sic]. Relator Kirk S. Corsello hereby incorporates and re-alleges herein paragraphs 1 through 113 as if set forth fully herein.

115 [sic]. Defendant Rotech terminated Relator Corsello in express violation of 31 U.S.C. § 3730(h).

116 [sic]. Pursuant to this statute, Relator Corsello is entitled to be reinstated at the same level of seniority he would have enjoyed absent this termination; an award of two times the amount of back pay due plus interest; compensation for special damages; and litigation costs and reasonable attorney's fees.

117 [sic]. Relator Kirk S. Corsello is also entitled to reasonable attorney fees and costs, pursuant to 31 U.S.C. § 3730(d)(1).

PRAYER FOR RELIEF

WHEREFORE, Relator Kirk S. Corsello prays for judgment:

(a) ordering Defendants to pay the United States Government damages sustained by it for each of the false claims presented or caused to be presented plus interest, and to Relator his attorney's fees, and costs;

(b) ordering Defendants to pay the United States government a civil penalty of $10,000 as required by law to be assessed against each named Defendant for each of the false claims presented or caused to be presented;

(c) ordering treble damages based upon the amount of damages sustained by the United States government as a result of the false claims;

(d) ordering Defendants Lincare and Rotech to reinstate Relator Corsello with the level of seniority he would have but for the discrimination; pay two times the amount of back pay due to Relator Corsello, plus interest; compensate Relator Corsello for special damages, litigation costs and reasonable attorneys fees;

(e) awarding Relator an amount the Court decides is reasonable for collecting the civil penalty and damages, which shall not be less than 25% nor more than 30% of the proceeds of this action or the settlement of any such claim; and

(g) [sic] granting such other relief as the Court may deem just and proper.

Respectfully submitted,

/s/ Mike Bothwell
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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA *ex rel.* KIRK S. CORSELLO, *et al.*, Plaintiffs, v. LINCARE, INC., LINCARE HOLDINGS, INC., AMERICAN HOME PATIENT, INC., ROTECH, INC., and ALAN VARRAUX, M.D., Defendants.	)	Civil Action No. 1:98-CV-0204-ODE

SECOND AMENDED COMPLAINT

(Filed Oct. 7, 1999)

Plaintiff-Relator Kirk S. Corsello ("Relator") hereby files the following Second Amended Complaint and alleges as follows:

JURISDICTION AND VENUE

1. This action arises under the 1986 Amendments to the False Claims Act, 31 U.S.C. §§ 3729 *et seq.*

2. This Court has subject matter jurisdiction over this action pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1345.

3. This Court has personal jurisdiction over the Defendants.

4. Venue is proper in this district under 28 U.S.C. §§ 1391(b), and 1391(c), and under 31 U.S.C. § 3732(a). At least one Defendant can be found, resides, and transacts business within the district, and the acts proscribed by the False Claims Act occurred within the district.

I. THE PARTIES

5. Relator Kirk S. Corsello is a citizen of the United States. He formerly worked for Defendant Lincare as a Center Manager for the South Orlando Center from August 15, 1995 to December 19, 1997. Mr. Corsello also worked for Defendant Rotech as Regional Sales Support person from August 7, 1998 to November 4, 1999.

6. Defendant Lincare, Inc. is incorporated in the State of Delaware with its principal place of business at 1937 U.S. 19 N., Suite 500, Clearwater, Florida 33764. Its registered agent for service of process is C.T. Corp., 1200 S. Pine Island Road, Plantation, Florida 33324.

7. Defendant Lincare Holdings, Inc. is incorporated in the State of Delaware with its principal place of business at 1937 U.S. 19 N., Suite 500, Clearwater, Florida 33764. Its registered agent for service of process is C.T. Corp., 1200 S. Pine Island Road, Plantation, Florida 33324.

8. Defendant American Home Patient, Inc. is incorporated in the State of Tennessee with its principal place of business at 5200 Maryland Way, Suite 400, Brentwood, Tennessee 37027. Its registered agent for service of process is Joseph F. Furlong, III, at 5200 Maryland Way, Suite 400, Brentwood, Tennessee.

9. Defendant Rotech, Inc. is incorporated in the State of Florida with its principal place of business at 4506 L.B. McCloud, Orlando, Florida 32811. Its registered agent for service of process is Usher Bryn, Esq., 2875 N.E. 190 First Street, Suite 802, Aventura, Florida 33180.

10. Defendant Alan Varraux, M.D. is a physician specializing in pulmonology. He can be served with process at Associates of Pulmny & Crtl. Cre Med, 60 West Columbia Street, Suite F, Orlando, Florida 32856.

11. Defendants Lincare, Inc. and Lincare Holdings, Inc., are collectively referred to herein as "Lincare."

12. Defendants Lincare, American Home Patient, Inc., and Rotech, Inc., are sometimes collectively referred to herein as "DME" Defendants. "DME" is an accepted acronym for "durable medical equipment," a category of healthcare hardware including oxygen tanks and supplies, hospital beds, wheelchairs, and the like.

II. FACTUAL ALLEGATIONS

13. The Second Amended Complaint states claims against the DME defendants which have as their common nexus the submission to the United States of Medicare and Medicaid claims for payment for durable medical equipment and related services which are false by virtue of their predication upon false Certificates of Medical Necessity ("CMN"). The common bond behind most, if not all, of the allegations against the DME defendants is that they pertain to a variety of methods by which Defendants obtained false CMNs. These methods include, among many others, payment of illegal kickbacks to physicians in exchange for patient referrals; forging of physician signatures

on CMNs; forging of other information on CMNs; and placing false information on CMNs to justify delivery of increased levels of service.

A. THE MEDICARE AND MEDICAID PROGRAMS

14. Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.*, establishes the Health Insurance for the Aged and Disabled Program, popularly known through HCFA, a component of HHS.

15. The Medicare program consists of two parts. Medicare Part A provides basic insurance for the costs of hospitalization and post-hospitalization care. 42 U.S.C. §§ 1395c-1395i-2 (1992).

16. Medicare Part B is a federally subsidized, voluntary insurance program that covers a percentage (typically eighty percent) of the fee schedule amount for physician and laboratory services. 42 U.S.C. §§ 1395k, 1395l, 1395x(s). Reimbursement for Medicare claims is made by the United States through the Health Care Financing Agency ("HCFA"). HCFA, in turn, contracts with private insurance carriers to administer and pay Medicare Part B claims from the Medicare Trust Fund. 42 U.S.C. § 1395u. In this capacity, the carriers act on behalf of HCFA. 42 C.F.R. § 421.5(b) (1994). As relevant to this case, the private carriers are referred to as "DMERCs." This is the acronym for "Durable Medical Equipment Regional Carriers."

17. Medicaid is a federally assisted grant program for the several states. Medicaid enables the States to provide medical assistance and related services to needy

individuals. HCFA administers Medicaid on the federal level. Within broad federal rules, each state decides who is eligible for Medicaid, the services covered, payment levels for services and administrative and operation procedures. The states directly pay physicians, with the states obtaining the federal share of the payment from accounts which draw on funds belonging to the United States Treasury. 42 C.F.R. §§ 430.0-430.30 (1994). The Federal share of each state's Medicaid program varies.

18. At all times relevant to this Complaint, the United States provided funds to the states through the Medicaid program, pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* Enrolled providers and suppliers of medical services to Medicaid recipients are eligible for reimbursement for covered medical services under the provisions of Title XIX of the 1965 Amendments to the Federal Social Security Act. By becoming a participating provider in Medicaid, enrolled providers and suppliers agree to abide by the rules, regulations, policies and procedures governing reimbursement, and to keep and allow access to records and information as required by Medicaid.

19. In order to receive Medicaid funds, enrolled providers and suppliers, together with their authorized agents, employees, and contractors, are required to abide by all the provisions of the Social Security Act, the regulations promulgated under the Act, and all applicable policies and procedures issued by the states.

20. Among the rules and regulations which enrolled providers agree to follow are to: (1) bill the Medicaid programs or DMERCs for only those covered services which are medically necessary; (2) neither bill the Medicaid

programs or DMERCs for any services or items which were not performed or delivered in accordance with all applicable policies nor submit false or inaccurate information to relating to provider costs or services; (3) not engage in any act or omission that constitutes or results in over-utilization of services; (4) not engage in such activities as obtaining lists of Medicaid eligibles from third parties or canvassing neighborhoods for direct contact with Medicaid eligibles, or payment of a referral or other fee which is not in compensation for medical care rendered to the recipient; (5) be fully licensed and/or certified under the applicable state and federal laws to perform the services provided to recipients; (6) comply with state and federal statutes, policies and regulations applicable to the Medicaid Program; and (7) not engage in any illegal activities related to the furnishing of services to recipients.

21. At all times relevant to this Complaint, the DME Defendants were participating Medicare Part B suppliers. The DME Defendants submitted claims to Medicare for services and durable medical equipment. All of the conduct alleged in the Second Amended Complaint is alleged to have occurred "knowingly," as that term is defined in the False Claims Act, 31 U.S.C. § 3729(b).

22. At all times relevant to this Complaint, the Medicare and Medicaid programs constituted a significant source of revenue for the DME Defendants.

B. ILLEGAL KICKBACKS AND REFERRAL SCHEMES BETWEEN DEFENDANT DME SUPPLIERS AND PROVIDERS IN VIOLATION OF 42 U.S.C. § 1395NN(A)(1) AND (H)(6) AND 42 U.S.C. § 1320A-7B(B)

23. One of the primary agents able to prevent Medicare and Medicaid fraud by medical service and medical equipment companies is the patient's treating physician. Recognizing this fact, Defendants Lincare, Rotech and American Home Patient engaged in a variety of illegal kickbacks to physicians designed to influence the physicians independent judgment, induce referrals and circumvent the physician – the first guardian of Medicare fraud. In each case where a patient was referred to Lincare, Rotech or AHP as the result of an illegal kickback, the DME Defendant would obtain from the physician, fill out, or complete a Certificate of Medical Necessity which was a false document by virtue of the fact that it resulted from an illegal kickback.

24. The DME Defendants have engaged in a practice of illegal kickbacks to referring physicians in order to have induce referrals of oxygen patients, including Medicare and Medicaid patients, to the DME suppliers by the referring physicians. These illegal kickbacks influence the referring physicians to prescribe unnecessary equipment and treatment to oxygen patients, including Medicare and Medicaid patients. These illegal kickbacks have resulted in false claims for payment to the United States. The illegal kickbacks utilized by the DME defendants include, but are not limited to, the following:

a) Cash payments for referrals;

b) Free tickets to professional sporting events;

c) Provision of free patient services and tests by the DME companies on behalf of referring physicians for which the referring physicians billed Medicare or private insurance carriers;

d) Provision of free or below market value equipment or medicine to referring physicians by the DME companies;

e) Paid Medical Directorships for referring physicians; and

1. Cash Payments

25. Defendants Rotech and Lincare engaged in a kickback scheme of making illegal cash payments to referring physicians. For example, Defendant Rotech made direct cash payments to referring physicians and/or members of their staff in the State of Texas, from December 1996 through January 1999. Upon information and belief, cash kickback payments were made to Doctors Pender, Gleason, Dryzer, Eden and/or their staffs by Rotech employees Wendy Baker and Karen Richter. Upon information and belief, similar kickback conduct took place throughout the State of Texas and everywhere Rotech does business throughout the statutory time period.

26. In Miami, Florida, Lincare made direct payments to Dr. Mederos and other physicians for referral of Medicare and Medicaid oxygen patients. This conduct occurred throughout the late 1980's and 1990's. The Neptune City

Lincare center has an arrangement with the local hospital wherein the hospital will order Durable Medical Equipment from Lincare and receive a 30% kickback. This kickback scheme was occurring as recently as March 1999. Upon information and belief this type of direct payment kickback occurred throughout the State of Florida and everywhere Lincare does business throughout the statutory time period.

2. Free Sports Tickets

27. Defendants Rotech and Lincare also provided illegal kickbacks to referring physicians and their staffs in the form of valuable tickets to professional sporting events. By way of specific example, Defendant Rotech provided referring physicians and their staffs with tickets to the Dallas Cowboys football games, the Texas Rangers baseball games, the Stars hockey games, and the Super Bowl. The purpose of providing these tickets was to induce referral of Medicare and Medicaid oxygen patients to Rotech. Some of these tickets were given to Dr. Agoro's staff, Doctors Pender, Gleason, Eden, Dryzer, McDonald, Lee and Burk in the Dallas-Fort Worth area. Professional Sports Tickets were provided to these and other referring physicians from at least 1996 through January of 1999 and, upon information and belief, the entire statutory time period wherever Rotech does oxygen and DME business.

28. In the South Florida area, Defendant Lincare provided referring physicians and their staffs with high priced tickets to the Miami Dolphins football games. Lincare provided season tickets to Doctors Green and Jacobson in West Palm Beach, Florida. The purpose of providing these tickets was to induce referral of Medicare

and Medicaid oxygen patients to Lincare. Upon information and belief, Lincare provided Miami Dolphins tickets to referring physicians and their staffs in the South Florida area during the entire statutory time period.

3. Free or Below Market Tests and Services

29. Defendants Lincare and Rotech engaged in the kickback scheme of providing free services or tests to patients of doctors and allowing the doctor to bill for the service or test. Specifically, the following are examples of each defendants engagement in the alleged kickback scheme:

a. Lincare employees in the Vero Beach, Florida area performed sleep studies for referring physicians, gave the results to the physicians, and allowed those physicians to bill Medicare for the sleep study actually performed by Lincare, all in exchange for the physicians' agreement to use Lincare to provide the tested patient's equipment and medicine. This conduct occurred in Vero Beach from 1988 to the present, throughout the State of Florida, and upon information and belief, everywhere Lincare does business during the same time period.

b. Lincare employees also performed free PFT, Oximetry and titration tests for referring physicians throughout the State of Florida and allowed the physicians to bill Medicare for these tests. This kickback scheme took place during the 1990's in Vero Beach, Florida, during at least 1995 through 1998 in Kissimmee, Florida, across the State of Florida and throughout the United States where Lincare does business.

c. Rotech employees performed free PFT, Oximetry and titration tests for referring physicians in the State of Texas and allowed the physicians to bill Medicare for the services. This kickback scheme was a [sic] continuous and ongoing during the time period, including but not limited to, 1998 and specifically included. Doctor Bakock in Waterford, Texas and services performed by Lori Pulps for Dr. Goldman in Fort Worth, Texas. Upon information and belief, this alleged scheme occurred during the entire statutory time period in all locations where Rotech does business.

d. On August 12-14, 1998, Rotech employee Anthony Succo spoke with medical professionals in the Myrtle Beach area. Anthony told them that Rotech would "do the setups in the doctors offices and allow them to bill for it." During the presentation, Mr. Succo mentioned other doctors who were already allowing Rotech to perform these activities in their offices. One such doctor is located in Wilmington, North Carolina.

e. Another Rotech employee, Patty Neil, was considered by her superiors to be an exemplary performer and had the largest base of patients on nebulizers and medicines ("neb-med patients") in her 90-branch region. Patty was promoted to area manager. On September 3, 1998, Patty Nell told Kirk Corsello that she would go into doctor's offices and do nebulizer treatments or Spirometry treatments and allow the doctors offices to bill Medicare for her services.

4. Free or Below Market Value Equipment or Medicine

30. Defendants Lincare, Rotech & American Home Patient engaged in the kickback scheme of providing free or below market value equipment and medicine to referring

physicians. Defendants each allowed the referring physicians to bill Medicare and Medicaid patients for the use of the free or below market equipment provided by Defendants. This particular kickback scheme also involved the illegal storage and dispersal of medications by Lincare, Rotech, and American Home Patient. When Lincare, Rotech, and American Home Patient drivers visited the home of a patient who had too much medicine these drivers would occasionally pick up the medicine and bring it back to the office for storage. When Lincare, Rotech, and American Home Patient sought to induce referrals from physicians, they would take from this store of illegal medicines to provide to a referring physician's patient on an emergency basis or as a "starter dose" in exchange for a referral from the physician.

31. Defendant Lincare provided free oxygen concentrators, oxygen tanks, nebulizers, and oximeters to referring physicians all across the State of Florida and in all places where Lincare does business. By way of example, in West Palm Beach, Florida, Lincare gave free equipment to Doctors Presser, De Olazabal, and Choy. The purpose of providing free equipment to physicians was to induce referral of Medicare and Medicaid patients. On information and belief, Lincare engaged in this kickback scheme throughout all its areas of operation during the entire statutory time period.

32. Lincare provided large quantities of DME equipment to Dr. Mederos in Miami at a below market value rate in order to induce referrals. Dr. Mederos would then bill patients, including Medicare and Medicaid patients, for the equipment at a higher amount through his own company. On information and belief, Lincare engaged in

this kickback scheme from the late 1980's through the 1990's.

33. Defendant Lincare provided free medicine to Doctors in all places where Lincare does business. Lincare Drivers would deliver excess quantities of Ipotropium and Albuterol to referring physicians so that the physicians could provide samples and starter doses to their patients. The purpose of providing free medicine was to induce referral of Medicare and Medicaid patients. Lincare engaged in this illegal kickback scheme during the entire statutory time period.

34. Defendant Rotech provided free oxygen concentrators, oxygen tanks, nebulizers, oximeters and CPAP machines to doctors throughout Texas and in most or all other places where Rotech does business. By way of example, Dr. Cash in Grapevine was provided with free oxygen tanks in 1998. Dr. Clavon in Bedford was provided with free oxygen tanks in 1998. Rotech provided free oxygen concentrators to Dr. Austin and Dr. Plum in Arlington in the late 1990s. The purpose of providing free equipment to physicians was to induce referral of Medicare and Medicaid patients. Upon information and belief, Rotech engaged in this illegal kickback scheme during the entire statutory time period.

35. Defendant Rotech provxxided [sic] free medicine to Doctors in all places where Rotech does business. Rotech Drivers delivered excess quantifies of Ipotropium and Albuterol to referring physicians so that the physicians could provide samples and starter doses to their patients. The purpose of providing free medicine was to induce referral of Medicare and Medicaid patients. Often these excess quantities of medicine were taken from the

homes of patients who had expired or had excess medicine delivered to them by Rotech and billed to Medicare and Medicaid. Rotech engaged in this illegal kickback scheme during the entire statutory time period.

36. As recently as June 14, 1999, Rotech employees, including Melissa Walker and Stacy Cline, offered to "screen charts" for potential referring physicians in Arkansas to determine whether patients needed to have Pulmonary Function Tests performed. These Rotech employees would then offer to perform PFTs on those patients, and rent the doctors a titration machine for below market value. The purpose of these offers was to induce referrals from the physicians.

37. Defendant American Home Patient provided free oxygen concentrators, oxygen tanks, PFT machines and oximeters to referring physicians all across the State of Florida and in all places where American Home Patient does business. Specifically, American Home Patient provided this type of free equipment to Dr. Oscar Rodas in Jacksonville, Florida. The purpose of providing the free equipment was to induce referrals of Medicare and Medicaid patients. American Home Patient engaged in this illegal kickback scheme during the entire statutory time period.

5. Medical Directorships

38. Defendants Rotech, Lincare and American Home Patient attempted to camouflage their kickbacks by entering into sham contractual arrangements with referring physicians called "medical directorships." Under these kickback schemes referring physicians were paid a monthly fee to act as a medical director for a division or

branch of the DME defendants. Contractually, the referring physicians are required to perform certain duties, such as "reviewing charts." In fact, the Defendants do not require, nor have they ever required, "medical directors" to perform any duties; or if any duties are "required," they are incidental to and required by the doctor-patient relationship. The purpose of setting up doctors with medical directorships is to induce referrals of oxygen patients, including Medicare and Medicaid patients to the DME Defendant companies. Upon information and belief, this practice of using medical directorships to camouflage kickbacks was in use company wide by Lincare, Rotech, and American Home Patient during the late 1980's and 1990's.

39. Lincare paid Dr. Wassen in Florida a monthly fee for acting as a medical director. In exchange, Dr. Wassen referred oxygen patients, including Medicare and Medicaid patients, to Lincare.

40. Romeo G. Guzman, M.D., and R. G. Guzman, M.D., P.A. Family and Geriatric Medicine received from Lincare at least four $750 checks as an inducement for referrals. The check dates are as follows: 6/6/95, 10/31/95, 12/29/95, and 6/30/95. Around January 15, 1995, Lincare prepared a document entitled Respiratory Therapy Services Agreement which was executed by Jim Kelly of Lincare and R.G. Guzman of R. G. Guzman, M.K., P.A. Family & Geriatric Medicine. The amount of the payments was set at $750 based on a Lincare formula which called for seven referrals per month at a projected payment amount of $50 per referral. It was later determined that Dr. Guzman was not referring sufficient patients to justify the payments, and the contract was terminated by Lincare. Dr. Guzman never performed any task for Lincare

which would justify payment by Lincare to Dr. Guzman. When Dr. Guzman asked Lincare sales representative Jennifer Wagner for his check, Relator Corsello referred the matter to his supervisor, Larry Simmons. Mr. Simmons instructed Mr. Corsello to print out a referral trend report for 1995 and track Dr. Guzman's referrals. Mr. Simmons and Lincare employee Jim Madison determined that Dr. Guzman had the potential to send five to seven Unit Dose (UD) referrals per month. Mr. Simmons said it was worth about $50 a patient for the doctor provide nebulizers directly to his patients as opposed to Lincare providing the services. The formula applied by Mr. Simmons and/or Mr. Madison to the Guzman analysis was as follows: five to seven patients per months times three months times $50 per patient = $750 per quarter year. When Simmons and Madison reviewed the reports, they concluded that Dr. Guzman was making too few referrals. His contract was thus terminated.

41. Defendant Alan Varraux, M.D. of Orlando, Florida has had a kickback relationship with Lincare since before 1990. Dr. Varraux had a medical director/consultant agreement with Lincare similar to that of Dr. Guzman, but pursuant to which Dr. Varraux gets paid several thousand dollars per month. As part of his kickback relationship with Lincare, Dr. Varraux has "unbundled" the two respiratory medicines (Albuterol and Ipotropium) on his prescriptions, which allows Lincare to bill more to Medicare. For cash payments and other kickbacks, Dr. Varraux refers his patients to Lincare.

42. Drs. John Daniel Mancini, Tolliver L. Higgins, Ivan Castro, and Winter Park Internal Medicine, M.D., P.A. sought a kickback arrangement with Lincare. On

behalf of the practice, Dr. Mancini asked Kirk Corselio if Lincare "needed any Medical Directors."

43. Lincare executive John Byrnes executed Medical Director agreements regularly. It is, and at all relevant times has been, Lincare policy to pay doctors medical director fees based on a formula concerned only with potential referrals.

44. Defendant Rotech paid Dr. Eden of Texas a monthly fee to act as the medical director of Texas Medical Diagnostics. Defendant Rotech also paid Dr. Charles Prochera of Bedford, Texas a monthly fee to act as a medical director for Rotech. In exchange, Dr. Eden and Dr. Prochera referred oxygen patients, including Medicare and Medicaid patients, to Rotech.

45. From no later than January 1988 through the present, Defendant AHP entered into medical director agreements with referring physicians across the United States. The medical directors were [sic] monthly salaries based solely on the expectation asnd [sic] performance of referrals. Accordingly, the amounts paid would vary widely based solely upon referrals. It was AHP policy during most or all of this time period that the referring physicians did not have to perform any act in order to get paid for being "medical directors." However, when the United States government requested documents from various durable medical equipment companies in conjunction with its investigation of this lawsuit, AHP's employees were informed that they should see if they could get the referring physicians to "do something" for their medical-director salaries.

46. AHP policy [sic] also recently changed its policies with respect to tracking equipment provided to potentially

referring physicians for free or below market value. AHP management directed subordinate managers and supervisors to "lose" the equipment on the inventory scrolls that AHP had given to doctors because AHP attorneys were "nervous" about "loaner equipment" to doctors. Terry Bennett was one of the regional managers who attempted to carry out this directive as well as the one concerning Medical Director Agreements. Mr. Bennett personally called all offices under his authority to tell them to "get rid" of the inventory sheet or to show that the doctor purchased the equipment.

47. Upon information and belief, this practice by AHP of manipulating inventory records to reflect either the absence of or payment for equipment placed for free in doctors' offices was done nationwide as part of a scheme to avoid detection of kickbacks.

48. Defendant American Home Patient paid Dr. Oscar Rodas and Dr. Bruce Yergin of Jacksonville, Florida a monthly fee for acting as Medical directors. Dr. Rodas was paid approximately $750 per month for many years. In exchange, Drs. Rodas and Yergin referred oxygen patients, including Medicare and Medicaid patients, to Lincare.

C. WAIVER OF THE PATIENT'S 20% CO-PAYMENT FOR OXYGEN SERVICES

49. A second weapon in the battle to prevent Medicare fraud is the 20% Co-Pay required of the Medicare patient, which is required unless the patient meets certain defined hardship requirements. The co-payment is designed to prevent Medicare fraud by drawing objection from a patient who is overcharged or provided with excess

or unneeded equipment or medicine. When the patient has to pay 20% of the cost, he or she is more likely to object to unnecessary treatment, medicine or equipment. In order to circumvent this Medicare fraud deterrent, Defendants Lincare and Rotech routinely waived the 20 percent co-pay regardless of whether the patient met the Medicare and/or Medicaid hardship requirements. Each time one of the Defendants waived a co-pay for a patient who did not satisfy the hardship criteria, any claim for payment submitted in connection therewith was a false claim because it misrepresented the actual price of the services provided.

50. Defendant Rotech engaged in a company-wide policy of waiving the 20 percent co-pay upon patient request, physician suggestion, or Rotech's own suggestion. Rotech required the patient to sign the hardship form to keep in its patient file without verifying whether the patient actually satisfied the hardship criteria. Upon information and belief, the majority of patients for whom Rotech waived the 20% co-pay did not qualify for the hardship waiver. Upon information and belief Rotech engaged in this practice during the late 1980's and 1990's in all locations where Rotech did business. By way of specific example, Rotech engaged in the practice of illegally waiving the 20 percent co-pay in Texas and Dothan, Alabama.

51. Defendant Lincare also engaged in a company wide policy of waiving the 20% co-pay upon patient request, physician suggestion, or Lincare's own suggestion. Like Rotech, Lincare required the patient to sign the hardship form to keep in its file without verifying whether the patient satisfied the hardship criteria. Upon information and belief, the majority of patients for whom Lincare

waived the 20% co-pay do not qualify for the hardship waiver. Upon information and belief, Lincare engaged in this illegal practice during the late 1980's and 1990's in all locations where Lincare did business. By way of specific example, Lincare engaged in the practice of illegally waiving the 20 percent co-pay throughout the State of Florida.

D. FALSIFICATION, FORGERY, OR ILLEGAL COMPLETION OF THE CERTIFICATE OF MEDICAL NECESSITY

52. A third safeguard against Medicare and Medicaid fraud mandated by Congress is the Certificate of Medical Necessity ("CMN"). A CMN is the physician's attestation that the durable medical equipment prescribed therein is medically necessary for treatment of the patient. The CMN is a preprinted form with four sections. Sections B (the medical necessity justification for the Durable Medical Equipment) and D (the physician's attestation and signature) are required by law to be completed by the physician. 42 U.S.C. § 1395n(a)(2)(B); 42 C.F.R. § 424.24(b). The entire CMN is required to be completed prior to the physician's signature in order to guard against Medicare fraud and ensure that patients receive only medically necessary treatment and services.

53. Lincare and Rotech have circumvented this third safeguard in a variety of ways, including but not limited to the following: having physicians sign blank CMNs; completing section B of the CMN prior to the physician's signature; filling in section B or altering the CMN after the physician's signature, but before submission to Medicare;

forging the physician's signature; and, providing unauthorized form CMNs for the physicians to follow when filling out CMNs.

54. The circumvention of CMN requirements by Lincare and Rotech has resulted in the submission of thousands of false claims for payment to the United States.

1. Blank CMNs

55. Defendants' Lincare and Rotech have engaged in a company-wide practice of obtaining signed, but otherwise blank, CMNs from referring physicians and using their employees to complete those portions of the certificates which only a physician or a physician's staff member is authorized to complete.

56. Between 1985 and 1989, and upon information and belief to the present, Lincare, by and through its employees, including by way of example Lynn Garapic (of the Altamonte Springs, Florida office), was involved in and supervised filling in of signed but otherwise-blank CMNs.

57. Lincare engaged continuously in the practice of receiving signed but otherwise-blank CMNs and filling them in during the entire statutory time period throughout the State of Florida, and upon information and belief, in all places where Lincare operates.

58. Lincare marketing representative Linda Drnek of the Okeechobee office was given an entire pad of signed blank CMNs by a doctor in Okeechobee to fill in wherever she thought a patient needed oxygen. The obvious illegality of this practice was compounded by the fact that Linda Drnek had no medical training.

59. Examples which demonstrate the routine employee completion of false CMNs to justify false claims for payment to the United States for durable medical equipment and oxygen refills which were themselves false because they were illegally filled in by Lincare employees including the following:

a. Patient H.B, CMN dated 1/9/97

b. Patient R. P. CMN dated 7/9/98

c. Patient R. T. CMN dated 12/27/94 (Lincare employee Leslie Caldwell)

d. Patient R. T. CMN dated 2/12/96 (Lincare employee Dennis McNamee)

e. Patient V. S. CMN dated 9/30/97 (Lincare employee Mark Cyman)

f. Patient V. S. CMN dated 6/22/95 (Lincare employee Jennifer Wagner)

g. Patient G. S. CMN dated 12/17/96 (Lincare employee Mark Cyman)

h. Patient H. M. CMN dated 7/18/97 (Lincare employee Mark Cyman)

i. Patient K.G., CMN dated 3/10/98, signed blank by Dr. Kenneth Baron and completed by typewriter after the doctors signature by Lincare employee, Marie Rennie

j. patient W.R. (signature not dated); a wheelchair CMN signed blank but not dated by Dr. George Mueller and filled in by typewriter after the doctor's signature by Lincare employee Marie Rennie.

60. Between 1996 and 1999, and upon information and belief during the entire statutory time period, Rotech,

by and through its employees, was involved in the receipt of signed, blank CMNs from referring physicians and the illegal completion of signed, but otherwise blank CMNs. This practice occurred regularly in the State of Texas and, upon information and belief, in all places Rotech does business.

61. Mike Loftis and Fred Willis, Rotech managers, have held out Anthony Succo as a "model" Rotech area manager. On August 11, 1998, Anthony Succo went to the office of Dr. Brian Adler and provided him a blank CMN. Anthony explained to the doctor that Anthony wished to put Mrs. Mildred Durgin on the NPPV program, and the doctor signed the blank CMN and gave it back to Anthony. The same day, Anthony made the same pitch in the same way to Dr. John Rathburn with the same results ostensibly for Mrs. Melinda Durkee. When Anthony Succo returned from the doctors' offices, he instructed a Rotech customer service representative fill in the CMNs. The two patients "signed up" on August 11, 1998 were the result of a process adopted by Rotech in South Carolina and, upon belief, the rest of the country. The program was that the NPPV Coordinator would go through the patient files and identify the patients who were NPPV candidates. These names were then turned over to someone like Anthony Succo who got the doctors to sign blank CMNs which were then filled-out by Rotech staff.

2. DME Companies Completing Section B of the CMN Prior to the Physician's Signature

62. Section B of the Certificate of Medical Necessity contains the following bold faced instruction: "Information in This Section May Not Be Completed by the Supplier of

the items/Supplies." This form of instruction is prescribed by 42 U.S.C. § 1395n(j)(2). Despite this requirement, employees of Lincare and Rotech, acting pursuant to standard company policies and procedures, routinely completed Section B of the CMN, thereby rendering false every such CMN and every claim for payment resulting therefrom.

63. Lincare and Rotech employees illegally completed Section B when they received signed and blank CMNs from referring physicians. Lincare and Rotech employees also engaged in a routine pattern and practice of illegally completing Section B prior to taking the CMN to the referring physician. This practice is in direct contravention of the instruction on the form and Medicare policy, and rendered all such CMNs and claims for payment resulting therefrom false.

64. Throughout the State of Texas, between 1996 and 1999 – and, upon information and belief, the entire statutory time period – Rotech customer service representatives filled out CMNs, including section B, for sales representatives to take to referring physicians for signature. Upon information and belief this practice was company-wide within Rotech.

3. Filling in Section B or Altering the CMN After the Physician's Signature, and Prior to Submission to Medicare

65. Employees of Lincare and Rotech, acting pursuant to company policy and procedures, routinely completed and/or altered Section B of the CMN after obtaining the referring physician's signature, thereby rendering false

every such CMN and every claim for payment resulting therefrom.

66. Upon information and belief, the completion of Section B of the CMN by Lincare employees, after receiving the physician's signature was widespread throughout Lincare during the entire statutory period.

67. Between 1985 and 1989 and upon belief from 1989 to the present, Lynn Garapic (of the Altamonte Springs, Florida office) was involved personally and in the supervision of Lincare employees who completed and/or altered Section B of patient CMN's after obtaining the referring physician's signature.

68. From before 1984 through his employment with Lincare which ended in late 1997, Larry Simmons was personally involved in and supervised Lincare employees who completed and/or altered Section B of patient CMNs after obtaining the referring physician's signature.

69. From before 1984 through 1997 and, upon belief, to the present, Lincare senior executive John Byrnes was personally involved in and supervised Lincare employees regarding the completion and/or alteration of Section B of patient CMNs after obtaining the referring physician's signature.

70. In at least 1997, Lincare executive Greg McCarthy was personally involved in and supervised Lincare employees regarding the completion and/or alteration of Section B of patient CMNs after obtaining the referring physician's signature.

71. From at least 1990 through 1997, Ron Pluchel was personally involved in and supervised Lincare employees regarding the completion and/or alteration of

Section B of patient CMNs after obtaining the referring physician's signature.

72. During 1996-1997 and upon belief to the present, Lori Demelio was personally involved in and supervised Lincare employees regarding the completion and/or alteration of Section B of patient CMNs after obtaining the referring physician's signature.

73. From at least 1995 through 1999, Mark Tobin was personally involved in and supervised Lincare employees regarding the completion and/or alteration of Section B of patient CMNs after obtaining the referring physician's signature.

74. In the course of illegally completing the CMNs, Lincare employees, acting pursuant to company policy and procedure, routinely added equipment not ordered by the Medicare patient's physician. Examples of equipment routinely added by Lincare employees include portable oxygen to an oxygen CMN and a pressure pad and pump to a hospital bed CMN. These additions were made to CMNs by Lincare employees so as to falsely bill Medicare for equipment not ordered by the physician as medically necessary. This practice was widespread throughout Lincare during the entire statutory time period.

75. Lincare has engaged in a company wide practice of changing dates on CMNs to permit billing to Medicare and/or Medicaid before the qualifying tests were done.

76. Specific examples of CMN's with section B filled in by Lincare employees in Florida, which specific examples are on information and belief representative of such false documents completed by Lincare employees throughout the Lincare system, include:

a. Patient initials M.A., 11/11/91, signed by Dr. Jose Deolazable with Section B completed by typewriter by a Lincare employee

b. Patient initials L.A., 7/28/98, signed by Dr. Andrew McDonald with the Section B diagnosis codes and length of need completed by in by Lincare employee, Marie Rennie

c. Patient initials R.A., 8/12/98, signed by Dr. Gabriel Breuer with Section B completed by Marie Rennie

d. Patient initials C.A., 11/21/90, signed by Dr. Richard Bergman with Section B completed by Marie Rennie

e. Patient initials F.A., 9/22/98, signed by Dr. Thomas Raymond with the Section B length of need and diagnosis code completed by Marie Rennie

f. Patient initials J.A., 8/5/98, signed by Dr. Allen Rosen with Section B completed by Marie Rennie

g. Patient intials [sic] J.B., 8/17/98, signed by Dr. Augustin Schwartz with Section B completed by Marie Rennie

h. Patient intials [sic] R.B., 9/4/98, signed by Dr. Robert Rosenthal with Section B completed by Marie Rennie

i. Patient D.B., 7/29/98, signed by Dr. Steven Mann with Section B completed by Marie Rennie

j. Patient initials W.B., 12/3/91, signed by Dr. Jonathan Greene with Section B completed by a Lincare employee under the supervison [sic] of Tom Titshaw

k. Patient intials [sic] H.C., 4/7/98, signed by Dr. Allen Rosen, Section B completed by a Lincare employee under the supervision of Marie Rennie

l. Patient initials J.C., 8/7/98, signed by Dr. Ira Warshaw with Section B completed by Marie Rennie

m. Patient M.C., 10/21/98, signed by Dr. Natalio J. Chediak with parts of Section B completed by Marie Rennie and changes made to questions 3 and 5 and initialed by Marie Rennie as if she were the physician

n. Patient initials S.D., CMN dated 8/10/98, signed by Dr. Louis Witonsky with Section B completed by Marie Rennie

o. Patient J.D., CMN dated 9/5/91, signed by Dr. Rudolph Scherer with the entire CMN filled out by a Lincare employee under the supervision of Tom Titshaw

p. Patient P.D.,. CMN dated 8/7/98, signed by Dr. San Pedro Benedicto with the typewritten portions of Section B completed by Marie Rennie, including the addition of diagnosis codes to qualify the patient for Medicare

q. Patient C.E., CMN dated 10/13/98, signed by Dr. Rogelio Choy with Section B filled out by a Lincare employee under the supervision of Marie Rennie

r. Patient C.F., CMN dated 12/12/91, signed by Dr. Brian Wasserman with the entire form filled out by a Lincare employee under the supervision of Tom Titshaw

s. Patient S.G., CMN dated 11/12/98, signed by Dr. Jim Johnson with Section B typed in by Marie Rennie

t. Patient A.G., CMN dated 10/7/91, signed by Dr. Brian Wasserman with Section B typed in by a Lincare employee under the supervision of Tom Titshaw

u. Patient G.H., CMN dated 11/15/98, signed by Dr. Samuel Jacobsen with Section B typed in by Marie Rennie

v. Patient D.H., CMN dated 4/5/91, signed by Dr. Alan Rosen with Section B completed by a Lincare employee under the supervision of Tom Titshaw

w. Patient T.H., CMN dated 6/5/98, signed by Dr. Adel Sidky with the typed portions of Section B completed by Marie Rennie and the doctor's initials next to changes in Section B forged by Marie Rennie

x. Patient C.J., CMN dated 12/2/91, signed by Dr. Stuart McCalley with the entire CMN filled out by a Lincare employee under the supervision of Tom Titshaw

y. Patient C.J., CMN dated 2/3/98, signed by Dr. Mark Hoyle with the entire CMN filled out by a Lincare employee under the supervision of Marie Rennie

z. Patient E.K., CMN dated 10/09/98, signed by Dr. Jonathan Greene with the typed portions of Section B completed by Marie Rennie and the handwritten portions of Section B completed by Lincare employee, Rick Imhof

aa. Patient P.L., CMN dated 11/20/91, signed by Dr. Gerald O'Connor with the entire CMN filled out by a Lincare employee under the supervision of Tom Titshaw

bb. Patient B.B.M., CMN dated 1/19/91, signed by Dr. Barry Davis with the entire CMN filled out by a Lincare employee under the supervision of Tom Titshaw

cc. Patient S.M., CMN dated 10/01/98, signed by Dr. Jonathan Greene with Section B typed by Marie Rennie

dd. Patient I.P., CMN dated 9/29/98, signed by Dr. Alan Koletsky with Section B typed in by Marie Rennie

ee. Patient N.P., CMN dated 12/20/91, signed by Dr. Alex Soller with the entire CMN filled out by a Lincare employee under the supervision of Tom Titshaw

ff. Patient R.Q., CMN dated 8/7/98, signed by Dr. Richard Seidelman with Section B filled in by Rick Imhof and question 3 changed and initialed by Marie Rennie

gg. Patient H.R., CMN dated 8/3/98, signed by Dr. Natalia J. Chediak with Section B corrections and physician initials filled out and forged by Marie Rennie

hh. Patient F.S., CMN dated 9/28/98, signed by Dr. David Vastola with Section B typed in by Marie Rennie

ii. Patient T.S., CMN dated 11/14/91, signed by Dr. James Jannotta with the entire CMN filled in by a Lincare employee under the supervision of Tom Titshaw

jj. Patient B.T., CMN dated 10/25/98, signed by Dr. Januariusz Styperek with Section B filled in by Marie Rennie

kk. Patient H.T., CMN dated 12/13/91, signed by Dr. Jonathan Green with the entire CMN filled out by a Lincare employee under the supervision of Tom Titshaw

ll. Patient H.V., CMN dated 11/21/91, signed by Dr. Rogelio Choy with the entire CMN filled in by a Lincare employee under the supervision of Tom Titshaw

mm. Patient Y.W., CMN dated 11/23/98, signed by Dr. Karen Kutikoff with section B typed in by Marie Rennie

nn. Patient J.W., CMN dated 3/18/91, signed by Dr. Jose DeOlazabal with the entire CMN filled in by a Lincare employee under the supervision of Tom Titshaw.

77. Upon information and belief, the completion of Section B of the CMN by Rotech employees after receiving the physician's signature was widespread throughout Texas, Alabama, and the entire Rotech territory during the entire statutory period.

78. In the Dothan, Alabama branch of Rotech, from at least 1989 to the present, Rotech employees changed data and codes on Certificates of Medical Necessity. Rotech supervisor Steve Griggs oversaw the process and was aware of changes of data and codes on sections of CMNs required to be filled out by only a physician or a member of his or her staff. The manager of the Dothan branch would routinely fill in portions of CMNs received by Rotech from referring physicians. The CMNs in the Dothan branch were routinely signed in different colored inks and handwriting different from the doctors. The practice of filling in Section B of CMNs by Rotech employees was so widespread that it was common for the CMN to contain handwriting that did not match the doctors signature or diagnosis code. The practice of filling in Section B of CMNs was routine in Dothan and throughout all Rotech territories.

79. Rotech, in the Dothan, Alabama branch and throughout its system, routinely altered Section B of oxygen CMNs to add portable oxygen to Medicare oxygen

patients after the CMNs were signed by the referring physician. These changes were made regardless whether the doctor ordered portable oxygen or whether the patient needed portable oxygen. The change was made for the purpose of falsely billing Medicare for medically unnecessary equipment for Medicare oxygen patients. This practice continued from at least 1989 to the present.

80. Rotech, in the Dothan, Alabama branch and throughout its system, routinely added pressure pads and pumps to hospital bed CMNs after the CMNs were signed by the referring physician. This practice continued from at least 1989 to the present.

81. Specific examples of CMNs filled out by Rotech employees, which specific examples are on information and belief representative of such false documents completed by Rotech employees throughout the Rotech system, include:

a. Patient A. G., CMN dated 3/2/99

b. Patient M. M., CMN dated 1/7/99 (revised 3/7/99);

c. Patient W. H., CMN dated 12/11/98

d. Patient A. M., CMN dated 2/19/99

e. Patient D. L., CMN dated 1/22/99.

4. Forging Physician's Signatures on Certificates of Medical Necessity

82. Certificates of Medical Necessity contain physician certification/attestation language at the bottom of the form. In 1990, this language read as follows:

> THE PATIENT HAS APPROPRIATELY TRIED OTHER TREATMENT MEASURES WITHOUT SUCCESS. OXYGEN THERAPY AND OXYGEN EQUIPMENT AS PRESCRIBED IS MEDICALLY INDICATED AND IS REASONABLE AND NECESSARY FOR THE TREATMENT OF THIS PATIENT. THIS FORM AND ANY STATEMENT ON MY LETTERHEAD ATTACHED HERETO HAS BEEN COMPLETED BY ME, OR BY MY EMPLOYEE AND REVIEWED BY ME. THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE, AND I UNDERSTAND THAT ANY FALSIFICATION, OMISSION, OR CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.

The form then has a signature line that reads: "Attending Physician's Signature (A STAMPED SIGNATURE IS NOT ACCEPTABLE)." In 1998, the certification/attestation language was changed to read:

> I certify that I am the physician Identified in Section A of this form. I have received Sections A, B, and C of the Certificate of Medical Necessity (including changes for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete to the best of my knowledge, and I understand that any falsification, ommission [sic], or concealment of material fact may subject me to civil or criminal liability.

The form then has a signature line for "PHYSICIAN'S SIGNATURE" and states that "SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE."

83. Despite the strict requirement that the prescribing physician review and sign the CMN, Lincare and Rotech both engaged in the practice of forging physician's signatures to CMNs.

84. Between 1985 and 1989 and upon belief from 1989 to present, Lincare employee Lynn Garapic personally forged, and supervised the forging by Lincare employees of, physician signatures to CMNs.

85. From before 1984 through his employment with Lincare which ended in late 1997 Larry Simmons supervised the forging of physicians' signatures on oxygen CMNs by Lincare employees. One of the doctor's signatures that Larry Simmons knew was often forged was Dr. Sheiman from West Palm Beach, Florida.

86. From before 1984 through 1997 and, upon belief, to the present, Lincare executive John Byrnes forged and supervised and directed the forging of physicians' signatures on oxygen CMNs by Lincare employees. One of the doctors signatures that John Byrnes knew was often forged was Dr. Sheiman from West Palm Beach, Florida. John Byrnes documented one instance of his own completion of CMNs via request to Tommy Titshaw, a Lincare employee in West Palm Beach, Florida. John Byrnes has repeatedly instructed Lincare employees that if they could not obtain physician signatures on CMNs they were to bring them to him for signature. During this same time frame, John Byrnes also stated to multiple Lincare employees that if they could not obtain a physician signature on a CMN, he would send it to a physician in West Palm Beach who would sign any other physician's CMN.

87. In at least 1997, Greg McCarthy supervised the forging by Lincare employees forging of physicians' signatures on oxygen CMNs.

88. From at least 1990 through 1997, Ron Pluchel supervised the forging by Lincare employees of physicians' signatures on oxygen CMNs.

89. In 1996 and 1997, and upon information and belief to the present, Lori Demelio personally forged, and supervised the forging by Lincare employees of, physician signatures on oxygen CMNs.

90. From at least 1995 through 1999, Lincare employee, Mark Tobin was involved in the practice of forging physician signatures to oxygen CMN's.

91. The forging of physician signatures by Lincare employees occurred in the Altamonte Springs center from at least 1985-1989, the West Palm Beach Center from at least 1989-1993, and the Vero Beach Center from at least 1993-1997.

92. Specific examples of CMNs with physician signatures forged by Lincare employees are as follows: patient B.P., 5-23-89, forged signature of Dr. Peter Sheiman of West Palm Beach on a DME CMN; patient B.P., 4/27/92, forged signature of Dr. Peter Sheiman on an oxygen CMN; and patient B.P., 3/29/88, forged signature of Dr. Peter Sheiman on an oxygen CMN.

93. The forging of physician signatures was so common throughout Lincare that some employees referred to the practice by the name Dr. Papsmear.

94. Defendant Rotech also engaged in the practice of forging physician signatures on CMNs. By way of example

of what is alleged on information and belief to be Rotech's systemwide practice, In the Dothan, Alabama branch from at least 1989 to 1998, Rotech's billing clerk routinely gave unsigned CMNs to the Dothan center manager who returned the CMNs with forged physician signatures.

95. In Texas Rotech branches from at least 1996 through 1999, physician signatures were forged on CMNs under the supervision of Rotech employee Karen Richter. The most commonly forged physician signature was that of Dr. Eden of Fort Worth.

96. Upon information and belief the practice of forging physician signatures to CMNs was company-wide within Rotech during the entire statutory time period.

97. Forging physician signatures is a violation of 42 U.S.C. §1395m(j)(2)(A)(iii) and/or 42 U.S.C. § 1320a-7a(i), and a Certificate of Medical Necessity with a forged physician signature is, if used in support of claims to the United States for payment, a false document in violation of 31 U.S.C. § 3729(a)(2).

5. Providing Unauthorized "Form" CMNs for Physicians to Foilow

98. Because the prescription of medical treatment and equipment must be based on a physicians' independent medical knowledge and judgment (and this independent judgment acts as a safeguard to Medicare fraud) Medicare guidelines and policy prohibits DME companies from providing "form" or "sample" CMNs to physicians to instruct them on how the DME company wishes the physician to fill out the CMN. *E.g.*, 42 U.S.C. § 1395m(j)(2)

99. In violation of this prohibition, Lincare and Rotech engaged in a practice of providing form or sample CMNs to physicians instructing them as to what the Defendants wanted the physician to prescribe.

100. The provision of form or sample CMN instructions occurred in the Rotech Dothan, Alabama branch from 1989 to 1999. Rotech provided documents to physicians in the Dothan area called "WRITTEN CONFIRMATION OF A VERBAL ORDER." This Written Confirmation functioned, and was intended to function, as instruction to the physician on how Rotech wanted the physicians to complete the CMNs.

101. In at least 1998, Texas offices of Rotech under the supervision of Karen Richter provided highlighted CMNs stapled to the front of blank CMNs instructing the physician on how Rotech wanted to the physician to fill out the CMN.

102. From at least 1998 to at least June of 1999, in the West Palm Beach, Florida area, Lincare provide form answer sheets accompanying CMNs instructing the physicians how Lincare wanted the physician to fill out the CMNs.

103. Upon information and belief, the practice of providing form or sample CMNs was widespread throughout both the Rotech and Lincare systems during the entire statutory time period.

104. Within Lincare and Rotech, the above CMN schemes and violations are nationwide in every geographic location where these companies do business. Upon information and belief, half or more of the CMNs submitted by

these companies are false because they violate the law in one or more of the ways set out above.

E. IMPROPER TESTING AND QUALIFICATION OF PATIENTS

104a. A fourth safeguard to prevent Medicare fraud is qualification criteria. In other words, a patient's health or physical condition must meet certain defined criteria in order for the patient to qualify for Medicare's payment for respiratory medicines and/or durable medical equipment. For example, in order to qualify a Medicare patient for oxygen therapy, Medicare requires documentation of hypoexmia. Medicare will pay for home oxygen therapy if a patient's oxygen saturation-test results are 88 percent or below at rest. Lincare and Rotech circumvented this safeguard against fraud by falsifying diagnoses and/or test results; manipulating tests to achieve a qualifying result; and/or qualification of patients by the DME defendants rather than an independent medical practitioner. This conduct violated 42 C.F.R. §§ 410.20(b) and 410.32(a).

1. Falsifying Diagnosis or Test Results

105. When filling in Section B of the CMNs as set forth above, Lincare employees falsified the answers to qualification questions and added diagnosis in order to qualify the patient for payment for treatment and equipment by Medicare. Upon information and belief, this practice was pervasive throughout the Lincare system during the entire statutory time period.

106. Specific examples of falsified tests and diagnosis, which specific examples are on information and belief representative of such false documents completed by

Lincare employees throughout the Lincare system, include:

a. Patient F.W., CMN dated 9/17/98, West Palm Beach Florida. The answer to question 7 in Section B of the oxygen CMN was invented and falsified by a Lincare employee under the supervision of Marie Rennie.

b. Patient E.W., CMN dated 10/26/90, West Palm Beach Florida. The diagnosis "Cor Pulmonale 416.9" was falsified and added by a Lincare employee under the supervision of Tom Titshaw to insure that the patient qualified for Medicare payment.

c. Patient J.A., CMN dated 8/5/98. The diagnosis code 780.53 was falsified and added by Marie Rennie in order to qualify the patient for Continuous Positive Airway Pressure (CPAP) system paid for by Medicare.

107. In at least 1998, and upon information and belief during the entire statutory time period, Rotech employees acting pursuant to Rotech policy falsified diagnosis and test results in order qualify patients for Medicare payment of oxygen therapy treatment. This conduct occurred in Texas and, upon information and belief, throughout the Rotech system.

108. Rotech employees in Fort Worth, Texas routinely falsified patient oximeter test results by using computer software. Employees took a printout of a qualifying oximeter test, change [sic] the name of the patient in the computer to the patient they wanted to qualify, and reprinted the test. This conduct occurred during at least 1998, and upon information and belief for most of the 1990's.

109. The falsification of diagnoses and test results by these defendants lead directly to submission of false documents and false claims for payment to the United States.

2. Manipulating Tests

110. Lincare and Rotech have also engaged in a practice of manipulating test conditions in order to get otherwise unqualified patients to qualify for medicine and DME to be paid for by Medicare.

111. Throughout the 1990's, Lincare employees in Florida were provided instruction in the way to manipulate oximeter machines to achieve a Medicare-qualifying test result for an unqualified patient, and in fact used these methods to achieve such results, leading to submission to the United States of false documents and false claims for payment.

112. Lincare and Rotech employees were instructed to, and did, manipulate and reduce the level of the patient's blood oxygen during an oximeter test by having the patient exert his or her self [sic] by exercise or walking to the mailbox while recording that the test was done at rest. These companies also manipulated the oximeter test by squeezing the oximeter on the patient's finger to restrict blood flow and obtain a lower blood oxygen reading. The purpose of this manipulation was to achieve a Medicare-qualifying test result from an unqualified patient. This practice occurred during the entire statutory time period and, on information and belief, continues today.

113. Upon information and belief these practices a [sic] company wide within Lincare and Rotech.

114. The manipulation of patient tests by these defendants has lead directly to submission of false claims for payment to the United States.

3. Self-Qualification of Patients

115. In order to guard against Medicare fraud, DME companies are prohibited from performing qualification tests and exams for patients to whom they will provide equipment. 42 C.F.R. § 410.20(b); 410.32(a).

116. Lincare therapists have engaged in a longstanding practice of self-qualifying patients. CMNs and claims for payment with respect to self-qualified patients are false.

117. For example, Lincare employee Mark Zayas purchased a pulse oximeter for Winter Park Internal Medicine. When the software was loaded on the machine, Lincare employees typed in the name Winter Park Internal Medicine so that Lincare could self-qualify patients while making it appear that the results were printed by Winter Park Internal Medicine. Lincare employees would also use this pulse oximeter to self-qualify patients from other physicians' offices, and so would white out or cut off the top of the results page that read "Winter Park Internal Medicine." In a Lincare Memo from Mark Zayas to Ron Pluchel dated April 8, 1997 concerning this software he wrote:

> Please be aware that the program i [sic] loaded on chris's [sic] laptop has winter park Internal medicine [sic] group on the top of each page when printed. please [sic] white out or cut off this portion

of each page printed from the program as it would be embarrising [sic] if this got back to them.

118. Specific examples of patients that were self-qualified by Lincare, which specific examples are on information and belief representative of such self qualifications completed by Lincare employees throughout the Lincare system, are:

a. Patient M.C., CMN dated 12/12/91. The oxygen saturation test was performed by a Lincare employee from the West Palm Beach office even though the CMN states that it was performed by Dr. Salmon Levin.

b. Patient M.C., CMN dated 2/26/98. The oxygen saturation test was performed by a Lincare employee even though the CMN states that it was performed by Augustin Schwartz.

c. Patient C.C., CMN dated 1/21/92. The oxygen saturation test was performed by a Lincare employee even though the CMN says it was performed by Dr. Chaplik. Dr. Chaplik, on information and belief, did not have an oximeter at the time of this test.

d. Patient W.H., CMN dated 6/21/91. The oxygen saturation test was performed by a Lincare employee even though the CMN says it was performed by Dr. Randy Gershwin. These are only a few examples of the widespread and pervasive self-qualification practices of defendant Lincare.

119. In Vero Beach Florida, Lincare employees were and continue performing sleep studies for patients and self-qualifying them for Medicare payment of oxygen therapy. Lincare employees would perform the tests,

record the results on the CMNs, and make the CMN look like the doctor performed the sleep studies.

120. These self-qualification practices occurred in Altamonte Springs, West Palm Beach and Vero Beach. Upon information and belief, the self-qualification practices of Lincare are company wide and occurred during the entire statutory time period.

121. Rotech also engaged in the practice of self-qualifying patients for oxygen equipment by performing oximeter tests on patients that Rotech had a financial interest in qualifying. Rotech engaged in the practice of self-qualifying patients by oximeter test from at least 1996 through the present, in the State of Texas.

122. Upon information and belief, Rotech engaged in a pattern and practice of self-qualifying patients throughout the Rotech system during the entire statutory time period.

123. The self-qualification of patients by these defendants has lead [sic] directly to submission of false claims for payment to the United States.

F. RE-RENTING CAPPED EQUIPMENT

124. Under Medicare guidelines, durable medical equipment items, such as wheelchairs and hospital beds are "capped." In other words, Medicare will only pay for these items for a limited period of time. After that time, the items are considered to be "paid out" or fully paid for.

125. Defendant Rotech engaged in a pattern and practice of re-renting capped equipment as new equipment in order to charge Medicare more money for durable

medical equipment that had already been fully paid for and "capped out."

126. By way of specific example, Rotech's Dothan, Alabama branch has engaged in the practice, from at least 1989 to the present, of picking up beds after patients died or no longer needed the beds and re-renting them again by falsely representing them as new. Rotech's Dothan office has a warehouse of old beds that Rotech delivers to Medicare patients, then billing Medicare for new beds. Rotech does not have matching invoices for the beds that it has billed Medicare for as new beds.

127. Rotech's Dothan, Alabama branch has also engaged in the practice of delivering used and capped wheelchairs to Medicare patients and billing Medicare for new wheelchairs. This practice has occurred from 1989 through the present.

128. By way of specific example, patient M.K. in Dothan, Alabama was provided a used wheelchair and Medicare was billed for a new wheelchair. Other examples from Dothan of charging Medicare for new equipment that was actually used include: patient M. H. on 2/22/99; patient K. H. on 2/28/99; patient E. H. on 2/27/99; patient R. J. on 2/27/99; and patient L.V.J. on 2/20/99.

129. Upon information and belief, the pattern and practice of re-renting capped DME equipment was company wide within Rotech during the entire statutory time period.

130. The re-renting of capped DME equipment by Rotech directly caused false claims for payment to be made to Medicare for equipment that had already "capped out."

G. BILLING MEDICARE FOR DME NO LONGER IN USE BY THE PATIENT

131. DME suppliers may only bill Medicare for durable medical equipment provided to Medicare eligible patients, while the equipment is in use and has not yet capped out.

132. Despite these requirements, Rotech's Dothan, Alabama branch continued bill [sic] Medicare for equipment no longer in use by patients.

133. Specific examples of bill for equipment no longer in use include: patient H. M. in Dothan, Alabama. Patient H.M. returned items of durable medical equipment to Rotech on or around July 2, 1998. However, Rotech continued to bill Medicare for the items until patient H.M. died. While Rotech was billing Medicare for the durable medical equipment, patient H. M. had been using durable medical equipment from a different company; patient I.J. D. got a standard wheelchair from Rotech's Dothan branch in May 1998. Patient I.J.D. moved to a nursing home five months later. Patient I.J.D.'s nursing home provides wheelchairs for the residents. Thus, the wheelchair previously provided by Rotech was no longer in use. However, Rotech continued to bill Medicare and received payments from Medicare while patient I.J.D. was in the nursing home. When a Rotech employee in the Dothan, Alabama branch complained about these matters, she was immediately fired.

134. Upon information and belief, Rotech's practice of billing Medicare for equipment no longer in use by Medicare patients was company wide during the entire statutory time period.

H. CHARGING MEDICARE MORE THAN PRIVATE INSURANCE COMPANIES ARE CHARGED FOR THE SAME SERVICES

135. DME suppliers are prohibited from charging Medicare more money for the same equipment or service than they charge private insurance companies.

136. Despite this prohibition, Rotech charged Medicare more for DME than it charged private insurance companies.

137. By way of specific example, Rotech's Dothan branch charged Medicare $314 for a breast prosthesis and brassiere. Rotech charged Blue Cross $299 for the same items.

138. Medicare would not pay claims if Medicare was aware that Rotech was charging Medicare more than private insurance companies for DME equipment and services. Thus, submitting claims for payment to Medicare for DME, where Medicare is charged more for the same DME than a private insurance company, is the submission of a false claim for payment.

139. Upon belief, the practice of charging Medicare more than private insurance companies for DME equipment and service occurred in Dothan, Alabama from 1989 to present and company wide during the entire statutory time period.

I. DELIVERY OF EXCESS AND UNNEEDED UNIT DOSE MEDICATIONS

140. Defendant Lincare engaged in a nationwide pattern and practice of sending refills of respiratory medicines to Medicare patients who already had a sufficient

supply of respiratory medicine. The purpose of sending the refills to Medicare patients was to insure Lincare's ability to bill Medicare monthly for the respiratory medication regardless of whether or not the patient needed the medication.

141. Lincare engaged in this practice under the guise of compliance with physician orders when in reality it was a scheme by Lincare to bill Medicare as much as possible, regardless of patient needs, to increase the profitability Lincare.

142. Lincare measured the percentage of patients that were sent their monthly refills on a branch by branch basis. This measurement is known as the Unit Dose compliance rate. Lincare employees across the States of Florida and Arizona, and upon information and belief all geographic areas where Lincare does business, were offered financial incentives to increase their unit does [sic] compliance rates.

143. By way of specific example, Lincare employee Lori Demello while a Manager in central Florida with Lincare, was illegally sending and instructing employees to send monthly refills without knowing whether they were needed. Center's under Lori Demello's management were almost 100 percent Unit Dose compliant, which, upon information and belief, is a practical impossibility. Upon information and belief, industry averages are less than 50 percent Unit Dose compliance [sic].

144. A respiratory therapist who worked for Lincare from 1995 to 1998 in the Tucson, Arizona area has been to the homes of Lincare Medicare patients that had boxes of oversupplied and unneeded Albuterol stacked up in closets and refrigerators. Some of these medications were more

than 6 months out of date. The cause of this overload of excess, unneeded and costly medicine was the practice of Lincare to send unit dose medications to Medicare patients regardless of need, in order to continue the false monthly billing of Medicare for medically unnecessary services and supplies.

145. The shipment of unnecessary and excess medicine resulted in false claims for payment to Medicare for respiratory medicines that were not medically necessary.

146. Defendant Rotech also engaged in a pattern and practice of sending refills of respiratory medicines to Medicare patients who already had a sufficient supply of respiratory medicine. The purpose of sending the refills to Medicare patients was to ensure Rotech's ability to bill Medicare monthly for the respiratory medication regardless whether or not the patient needed the medication.

147. Rotech engaged in this practice under the guise of compliance with physician orders when in reality it was a scheme by Rotech to bill Medicare as much as possible, regardless of patient needs, to increase the profitability [sic] Rotech.

148. By way of example, the Rotech Dothan, Alabama branch, from at least 1989 to at least 1998, routinely ordered monthly refill medicines for its Medicare patients, including both oxygen patients and diabetic patients, regardless whether the patients needed the medicine and without any Rotech employee checking the patient's needs. In or about mid-1998, Rotech employees were instructed to call the patients about respiratory medicines. However, the policy and practice never changed for diabetic supplies.

149. The shipment of, and billing Medicare of for [sic], unnecessary and excess medicine resulted in false claims for payment to Medicare for respiratory medicines that were not needed by the Medicare patients.

J. UNBUNDLING PRESCRIPTIONS FOR RESPIRATORY MEDICINES

150. Two primary medicines are used for respiratory therapy: Albuterol and Ipotropium. Typically, when both medicines are needed by the patient, the physician prescribes them in combination in a single prescription. Medicare pays a set amount for the combination prescription of Albuterol and Ipotropium.

151. In order to avoid the effect of the flat fee for the combined prescription, Lincare persuaded physicians to "unbundle" the prescription and prescribe Albuterol and Ipotropium separately. The result was of no patient benefit. However, the unbundling allowed Lincare to bill Medicare more money for the same medicines, in contravention of Medicare and Medicaid policy and through the submission of false claims for payment.

152. Defendant Dr. Alan Varraux is one of numerous physicians who worked with Lincare to unbundle the two prescriptions to facilitate unlawful overcharges to Medicare. Dr. Varraux, of Orlando, Florida, has a relationship with Lincare dating back to before 1990. Pursuant to his relationship with Lincare, Dr. Varraux has unbundled the two respiratory medicines (Albuterol and Ipotropium) on his prescriptions allowing Lincare to bill more to Medicare.

153. Upon information and belief, the practice of unbundling Albuterol and Ipotropium has been ongoing in every geographic region where Lincare does business, since at least 1990.

154. The unbundling of prescriptions for Albuterol and Ipotropium has resulted in Lincare making thousands of false claims for payment to Medicare.

K. TROLLING FOR MEDICARE PATIENTS AND THE ADDITION OF EQUIPMENT TO MEDICARE PATIENTS

155. Lincare and Rotech both engaged in company-wide practices of "trolling" for new Medicare patients and "trolling" for current patients to put on new Medicare billable equipment. The term "trolling" designates the practice of employees of DME suppliers, including Defendants Lincare and Rotech, of scanning the files of physicians with whom the supplier's employees have a relationship and locating patients who, while not presently receiving home oxygen services, may be eligible therefore; or who, while receiving home oxygen services, are not receiving the maximum amount of services offered by Defendants. Defendants then solicit the physicians to authorize increased services to their patients regardless of medical need. The term "trolling" also designates the practice of DME providers, including Defendants Lincare and Rotech, of going through their in-house files to identify patient customers who are receiving services at less than the maximum level at which Defendants are able to seek Medicare reimbursement. Such patient customers are then solicited to increase their level of supplies from Defendant, who executes the necessary paperwork, obtains the relevant physician signatures in violation of the

CMN requirements, and waives the co-payment so that the increased services are free to the patient customer.

156. One method of trolling used by Lincare and Rotech was to review the patient lists of referring physicians. Lincare and Rotech were allowed unfettered access to some of the patient records of some of the referring physicians with whom they had kickback arrangements. In these records, Lincare and Rotech would find patients who were not yet prescribed all of the most profitable medicines, equipment or services available. With the help of the referring physicians with whom Lincare and Rotech had kickback arrangements, these identified patients would be prescribed the more profitable medicines, equipment and services regardless of medical necessity.

157. Lincare obtained patient lists for the purposes of trolling from various physicians by proposing to teach patients how to use certain durable medical equipment, such as an inhaler, for free. This practice was known as the Medisist Program.

158. Lincare actively engaged in company-wide trolling of its own patient lists. It is the widespread practice of Lincare to troll its own patient lists to identify patients that they can persuade referring physicians (many with kickback arrangements) to prescribe additional and more profitable equipment, medicine and treatment to be paid for by Medicare, regardless of medical necessity. At Lincare the program usually begins by charting the treatment, medicine and equipment currently received by Lincare's Medicare patients. Lincare then provides cash incentives to its employees to get the patients converted to all possible equipment, treatment and medicine, regardless of necessity or usage. Most often this

is achieved by cooperation with referring physicians with whom Lincare has kickback arrangements. The progress for many Lincare patients is from oxygen to nebulizer to medicines to Bi-pap to Bi-pap ST. The Bi-pap ST equipment is placed in patients' homes by Lincare as often as possible regardless of medical necessity because it is a highly profitable "uncapped" item for Medicare payment.

159. On the West Coast of Florida, Lincare engaged in a specific trolling campaign to convert Medicare patients on metered dose inhalers to nebulizers and medicines. Metered dose inhalers are not paid for by Medicare. Lincare obtained a list of 245 patients in the territory with a diagnosis of COPD. Lincare then divided up the territory among Lincare employees who were instructed to call all 245 patients to determine their current medications. if the patient was using a metered dose inhaler, the Lincare employee would try to get the patient to agree to "convert" to the medicines and nebulizer that would be paid for by Medicare. If the patient agreed, Lincare employees would advocate the conversion to the patient's physician. Many of these physicians were involved in kickback arrangements with Lincare. The conversions were attempted and completed regardless of medical necessity. This practice occurred throughout the state of Florida from at least 1996 through 1999, and upon information and belief in all geographic areas where Lincare does business, during the entire statutory time period.

160. In South Carolina, and upon belief in all areas where Rotech does business, Rotech engaged in trolling for patients to place on non-invasive positive pressure ventilation ("NPPV"), also known as Bi-Pap ST. Rotech called this the NPPV Program. Rotech began by designating a Rotech employee as the NPPV coordinator for the geographic

area. The job of the coordinator was to troll through Rotech patient files and find patients to put on the NPPV program. On August 10, 1998, the NPPV coordinator for South, Carolina was performing this job at the Rotech Surfside Beach branch. On information and belief, Rotech engaged in a similar trolling practice for NPPV Medicare patients in the Dothan, Alabama branch and throughout the Rotech system. Rotech trolled for patients to put on the NPPV program, regardless of necessity, because the Bi-Pap St is a profitable uncapped item for Medicare payment.

161. Rotech also engaged in the practice of trolling its internal patient lists to find patients to convert to the medicines Albuterol and ipotropium. This trolling program was known as the Neb. & Meds. or the Neb/Meds program. Specifically, on August 19, 1998 Steve Miller (a Rotech employee from Orlando, Florida) was training Rotech employees on the Neb/Meds trolling program in Monroe, North Carolina. Rotech begins by printing internal reports of Rotech Medicare patients who are on oxygen, but not Albuterol and ipotropium. Rotech's respiratory therapist is instructed to pick out five patients from the list on a given day and visit them for the purpose of trying to get them on both medicines separately in some form of unbundling. On August 19, 1998 Steve Miller and a local Rotech respiratory therapist were successful in converting all five patients seen in Monroe, North Carolina to both medicines.

162. Rotech also engaged in the practice of trolling its internal patient lists for purposes of converting Medicare patients with a diagnosis of COPD to Neb/Meds. In Texas, during this same time period, Rotech drivers were paid a $25 incentive per medicine for each Medicare patient conversion. The drivers were paid $50 for each

patient they convinced to convert their oxygen supplier to Rotech and $100 for talking a patient into converting NPPV a/k/a Bi-Pap ST. This incentive program was known as HIP (the "Hustle Incentive Program") These practices occurred across the State of Texas from at least 1996 to 1999. Upon information and belief, Rotech engaged in the practice of Trolling for Neb/Meds patients in all geographic regions where Rotech does business, during the statutory time period.

163. Illegal trolling of Medicare patients by Lincare and Rotech leads to the submission of false claims for payment, because the Medicare patient has not sought the treatment through an independent physician. Rather, the DME companies have sought out the patient in order bill Medicare for equipment, medicine and treatment provided by the DME defendants. This practice results in claims for payment from Medicare that would not be made in the absence of illegal trolling by Lincare and Rotech.

L. CONVERSION TO MOTORIZED WHEELCHAIRS

164. In the Dothan, Alabama branch, from at least 1989 to the present, Rotech converted Medicare patients with light weight wheelchairs to electric wheelchairs, regardless of medical necessity, because electric wheelchairs are a high profit item. Rotech billed Medicare for electric wheelchairs without proper doctor certification. Two examples were the wheelchairs provided to William Shoelos and Loyd Dixon in March of 1999.

165. Upon information and belief, the effort to convert Medicare patients to electric wheelchairs has been company wide with Rotech from 1989 to the present.

Evidence of the continued effort by Rotech to covert Medicare patients from light weight wheel chairs to electric wheelchairs was noted on September 10, 1998 in Spartanburg, South Carolina. On this date and location, a Rotech employee emphasized the "wheel-chair push". The program involved going through all of the patient lists for patients with light weight wheelchairs to see if they could be converted to power wheelchairs.

166. The Rotech practice of converting lightweight wheelchair Medicare patients to electric wheelchairs, when the patient does not qualify for an electric wheelchair, has caused false claims for payment to be submitted to the United States.

167. After receiving notice of this lawsuit and of a possible government investigation, Lincare has sent at least two written directives to its employees to avoid cooperating with the government investigators.

M. ADDITIONAL FALSE CLAIMS

168. When Lincare senior executive John Byrnes worked for Lincare in Mobile, Alabama, he routinely billed Medicare for a full refill of oxygen regardless of how much oxygen it actually took to refill the patients tanks. He instructed those under him to do the same.

169. Upon information and belief, Rotech has billed Medicare for nursing home patients in Oklahoma that did not even exist. Upon information and belief, Dan James, a regional manager for Rotech was involved in this matter. Upon information and belief, Rotech has billed Medicare for nursing home patients in Oklahoma that did not even

exist. Upon information and belief, Dan James, a regional manager for Rotech was involved in this matter.

N. RETALIATORY DISCHARGE - VIOLATION OF 31 U.S.C. § 3729(H)

1. Lincare

170. Relator Kirk S. Corsello was employed by Defendant Lincare as a center manager in Orlando from August, 15 1995 to December, 19 1997.

171. In his capacity as a center manager, Mr. Corsello became aware of specific fraudulent acts and schemes perpetrated by Lincare through its employees.

172. While working for Lincare, Mr. Corsello also learned facts indicating that other suppliers of durable medical equipment engaged in the same fraudulent practices as did Lincare.

173. Upon written invitation to all Lincare employees to report known or suspected fraud within Lincare to the corporate compliance department, Mr. Corsello responded by reporting Medicare fraud and abuse in a certified-mail letter dated June 12, 1997 to Richard Butler. This letter was received and signed for on June 16, 1997. In the letter, Relator Kirk Corsello related his fear of retaliation.

174. After bringing Medicare fraud and abuse to the attention of Lincare's compliance department, Mr. Corsello was continually passed over for promotions and bonuses.

175. Mr. Corsello continued to report Medicare fraud and abuse within Lincare in his Center Manager reports.

176. Mr. Corsello continued to investigate and acquire evidence of Medicare fraud within Lincare during his employment.

177. After bringing Medicare fraud within Lincare to the attention of Lincare's compliance department and continuing to do so in his Center Manager reports, Mr. Corsello was fired as a result of his lawful efforts to expose and rectify Medicare fraud within Lincare.

178. All actions taken by Relator Kirk Corsello that gave rise to his discharge by Defendant Lincare were taken in an attempt to assure Lincare's compliance with Medicare rules and regulations.

179. Mr. Corsello was threatened and believed himself to be in personal danger for his investigations, discoveries, and exposure of fraud within Lincare.

180. Defendant Lincare discharged Kirk S. Corsello from his position as center manager in violation of 31 U.S.C. § 3730(h).

2. Rotech

181. Kirk S. Corsello was employed by Defendant Rotech from August 7, 1999 to November 4, 1999 as a Regional Sales Support person.

182. During his term of employment, Relator Kirk Corsello was pursuing this False Claims Act case against Defendant Rotech. At the time of Kirk Corsello's employment with Defendant Rotech, this False Claims Act case was under seal.

183. Defendant Rotech learned of this False Claims Act case, in which Rotech is a Defendant, case [sic] while the case was under seal.

184. Upon learning of this False Claims Act case filed against Defendant Rotech by Relator Kirk Corsello, Defendant Rotech fired Mr. Corsello.

185. Defendant Rotech discharged Mr. Corsello in violation of 31 U.S.C. § 3730(h).

186. Lincare, Inc. and Lincare Holdings, Inc. are vicariously liable for the actions of their subsidiaries, divisions, employees, officers, and directors.

187. Rotech, Inc. and its parent company are vicariously liable for the actions of their subsidiaries, divisions, employees, officers, and directors.

188. American Home Patient, Inc. is vicariously liable for the actions of their subsidiaries, divisions, employees, officers, and directors.

COUNT I

FALSE CLAIMS ACT VIOLATIONS

189. Relator hereby incorporates and re-alleges Paragraphs 1-188 as if fully set forth herein.

190. Defendants, by and through their agents, officers and employees, presented and caused to be presented to officers or employees of the United States false or fraudulent claims for payment or approval, in violation of 31 U.S.C. § 3729(a)(1).

191. Defendants, by and through their agents, officers and employees, presented and caused to be presented to

officers or employees of the United States false records or statements to get false claims paid, in violation of 31 U.S.C. § 3729(a)(2).

192. Defendants Lincare and Varraux conspired to defraud the Government by getting false claims allowed or paid in violation of 31 U.S.C. § 3729(a)(3), and each committed numerous overt acts in furtherance thereof.

193. The United States has been damaged as a result of Defendants' violations of the False Claim Act in an amount to be proven at trial. The United States is entitled to this sum as reimbursement for monies obtained by the Defendants for fraudulent claims submitted to the United States.

194. The United States is entitled to three times the total damages sustained as a result of Defendants' violations of 31 U.S.C. § 3729(a)(1)-(3).

195. The United States is entitled to a civil penalty of between $5,000 and $10,000 as required by 31 U.S.C. § 3729(a) for each of Defendants' fraudulent claims.

196. Relator is entitled to reasonable attorney fees and costs pursuant to 31 U.S.C. § 3730(d)(1).

COUNT II

FALSE CLAIMS ACT RETALIATION VIOLATION (DEFENDANT LINCARE)

197. Relator hereby incorporates and re-alleges paragraphs 1 through 196 as if fully set forth herein.

198. Defendant Lincare terminated Relator Corsello in express violation of 31 U.S.C. § 3730(h).

199. Pursuant to this statute, Relator Corsello is entitled to be reinstated at the same level of seniority he would have enjoyed absent this termination; an award of two times the amount of back pay due plus interest; compensation for special damages; and litigation costs and reasonable attorney's fees.

200. Relator is entitled to reasonable attorney fees and costs, pursuant to 31 U.S.C. § 3730(d)(1).

COUNT III

FALSE CLAIMS ACT RETALIATION VIOLATION (DEFENDANT ROTECH)

201. Relator Kirk S. Corsello hereby incorporates and re-alleges paragraphs 1 through 200 as if fully set forth herein.

202. Defendant Rotech terminated Relator Corsello in violation of 31 U.S.C. § 3730(h).

203. Pursuant to this statute, Relator Corsello is entitled to be reinstated at the same level of seniority he would have enjoyed absent this termination; an award of two times the amount of back pay due plus interest; compensation for special damages; and litigation costs and reasonable attorney's fees.

204. Relator Kirk S. Corsello is also entitled to reasonable attorney fees and costs, pursuant to 31 U.S.C. § 3730(d)(1).

PRAYER FOR RELIEF

WHEREFORE, Relator Kirk S. Corsello prays for judgment:

(a) ordering Defendants to pay the United States Government three times its actual damage resulting from each of the false claims presented or caused to be presented plus interest; and to Relator his attorney's fees and costs;

(b) ordering Defendants to pay the United States government a civil penalty of $10,000 as required by law to be assessed against each named Defendant for each of the false claims presented or caused to be presented;

(e) ordering Defendants Lincare and Rotech to reinstate Relator Corsello with the level of seniority he would have but for the discrimination; pay two times the amount of back pay due to Relator Corsello, plus interest; compensate Relator Corsello for special damages, litigation costs and reasonable attorneys fees;

(e) awarding Relator an amount the Court decides is reasonable for collecting the civil penalty and damages by pursuing this matter, which award shall not be less than 25% nor more than 30% of the proceeds of this action or the settlement of any such claim; and

(f) granting such other relief as the Court may deem just and proper.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I, hereby certify that I have served a copy of the above and foregoing upon all counsel of record, by placing a copy in the U.S. mail, postage prepaid on this the 8 day of October, 1999.

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA ex rel. KIRK S. CORSELLO, and KIRK S. CORSELLO, Plaintiffs, v. LINCARE, INC.; LINCARE HOLDINGS INC.; AMERICAN HOMEPATIENT, INC.; ROTECH INC.; and ALAN VARRAUX, M.D.; Defendants.	CIVIL ACTION NO. 1:98-CV-0204-ODE

ORDER

(Filed Mar. 9, 2001)

This *qui tam* civil action, filed pursuant to the False Claims Act, 31 U.S.C. § 3729 *et seq.*, is before the court on (1) American HomePatient, Inc.'s ("American HomePatient" or "Defendant") motion to dismiss Relators second amended complaint for failure to comply with Federal Rule of Civil Procedure 9(b) and for failure to state a claim; (2) Lincare Inc. and Lincare Holdings Inc.'s ("Lincare" or "Defendant") renewed motion to dismiss pursuant to Federal Rules of Civil Procedure 9(b) and 12(b)(6); (3) Lincare's motion to dismiss qui tam claims on constitutional grounds; (4) Lincare's motion to file a supplemental brief in light of new authority; (5) Lincare's motion to dismiss pursuant to 31 U.S.C. § 3730(b)(5) and Federal Rule of Civil Procedure 12(b)(1); and (6) Lincare's motion for leave to file supplemental brief in light of *Clausen*

decision. All motions are opposed by Relator Kirk S. Corsello ("Relator"). For the reasons set forth below, Defendants, motions to dismiss pursuant to Federal Rule of Civil Procedure 9(b) and 12(b)(6) are granted, Lincare's motion to file a supplemental brief in light of new authority and motion for leave to file supplemental brief in light of *Clausen* decision are granted nunc pro tunc, and Lincare's motion to dismiss quitam claims on constitutional grounds and motion to dismiss pursuant to 31 U.S.C. § 3730(b)(5) and Federal Rule of Civil Procedure 12(b)(1) are dismissed as moot.

Relator brought this action on January 22, 1998. under the False Claims Act, 31 U.S.C. § 3729 *et seq.* He alleges that Defendants[1] engaged in Medicare fraud against the United States government through various fraudulent "schemes" designed to obtain Medicare payments unlawfully. Relator does not allege that he has been personally injured by Defendants' alleged actions, but only that the United States government has been harmed. The United States has not intervened in this case.

The complaint was unsealed and service was authorized on November 6, 1998. However, Relator failed to perfect service on any of the Defendants. On June 18, 1999, the court granted Relators motion to file an amended complaint, but cautioned Relator as follows:

> The *Qui Tam* Act was not enacted in order to give the relator an unlimited opportunity to perfect its complaint or the government an unlimited opportunity to elect to intervene. However,

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[1] Originally, Relator named fifty-six entities and ninety-nine John Does and John Doe Corporations as defendants.

> in consideration of judicial economy and in light of the fact that none of the parties to this action have yet been served, the court hereby GRANTS Plaintiff's motion for leave to amend the complaint. Plaintiff shall submit an amended complaint within ten (10) days of the entry of this order. *The amended complaint shall fully comport with the requirement of Fed.R.Civ.P. 9(b) which requires that fraud be plead with specificity.* "The plaintiff's complaint must allege the details of the defendant's allegedly fraudulent acts, when they occurred, and who engaged in them." *Cooper v. Blue Cross and Blue Shield of Florida,* 19 F.3d 562 568 (11th Cir. 1994). There will be no further extensions of time.

United States ex rel. Corsello v. Lincare, Inc., No. 1:98-CV-0204-ODE, slip op. at 2 (N.D. Ga. June 18, 1999) (emphasis added). Relator then served his first amended complaint on July 14, 1999 which, *inter alia,* amended the named defendants.

In an apparent attempt to cure some of the alleged deficiencies in his first amended complaint, Relator filed his second amended complaint on January 13, 2000, further reducing the number of named defendants. The remaining Defendants now include Lincare Inc., Lincare Holdings Inc.,[2] Rotech Medical Corporation ("Rotech" or "Defendant"),[3] American HomePatient, Inc., and Alan Varraux. Lincare Inc. and Lincare Holdings Inc. are

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[2] In his pleadings, Relator refers to Lincare Inc. and Lincare Holdings, Inc. collectively as "Lincare." Because it is impossible to ascertain to which Lincare entity Relator refers, the court likewise will refer to both entities collectively.

[3] Rotech filed a notice of bankruptcy stay on February 25, 2000.

nationwide providers of oxygen services and equipment to patients in their homes. Varraux is a physician specializing in pulmonology who allegedly had a medical director/consultant agreement with Lincare. American HomePatient is a nationwide supplier of durable medical equipment.

Relator states that he was employed by Lincare as a Center Manager for the South Orlando Center from August 15, 1995 through December 19, 1997. [Compl. at 2]. Additionally, according to Rotech, Relator obtained employment as a marketing representative for Rotech in Charleston, South Carolina from August, 1998 through November 4, 1998. [*See* Rotech's Mot. to Dismiss Amended Compl. at 4]. Based upon information allegedly obtained during his employment with Lincare and Rotech, Relator asserts that Defendants engaged in the following schemes resulting in violations of the False Claims Act.

Relator alleges that Defendants Lincare, Rotech, and American HomePatient provided illegal kickbacks to physicians to induce referrals of oxygen patients including cash payments, sporting events tickets, free patient services and tests, free or below market value equipment or medicine, and paid medical directorships.

With respect to Rotech and Lincare only, Relator alleges the existence of the following fraudulent schemes: 1) waiver of patients' twenty percent co-payment for oxygen services in the absence of any hardship to avoid patients' objections to overcharges or unnecessary equipment or medicine; (2) falsification, forgery, or illegal completion of certificates of medical necessity ("CMN") to enable the provision of unnecessary treatment and services; (3) improper testing and qualification of patients for

certain services by falsifying diagnoses and/or test results, manipulating tests to achieve a qualifying result, and qualification of patients by Defendants rather than an independent medical practitioner; (4) delivery of excess and unneeded unit dose medications; and (5) "controlling" for Medicare patients by reviewing physician files to identify patients who may be eligible for oxygen services.

Relator alleges that Rotech employed the following methods to defraud the Medicare system: (1) re-renting equipment which has already been fully paid for by Medicare (referred to as "capped" equipment); (2) billing Medicare for durable medical equipment (DME) no longer in use by the patient; (3) charging Medicare more than private insurance companies are charged for the same services; (4) converting Medicare patients to motorized wheelchairs, regardless of medical necessity, which can be billed at a higher rate; and (5) billing Medicare for nursing home patients in Oklahoma that did not exist.

Relator further alleges that Lincare relied on the following practices to submit improper claims for Medicare reimbursement: (1) "unbundling" prescriptions for respiratory medicines to enable Lincare to bill Medicare at a higher rate than that authorized when the medicines are prescribed together; and (2) billing for a full refill of oxygen regardless of the amount of oxygen needed to refill the patients' tanks.

In his second amended complaint, Relator asserts three counts of False Claims Act violations based on the aforementioned allegedly fraudulent schemes. In Count I, Relator alleges that all Defendants violated 31 U.S.C.

§ 3729(a)(1)[4] and (a)(2) by presenting false claims for payment and by submitting false records or statements for the purpose of payment of false claims. [*See* Compl. at 53-54]. Relator further alleges that Defendants Lincare and Varraux conspired to defraud the government by getting false claims allowed or paid in violation of 31 U.S.C. § 3729(a)(3). In Count II, Relator alleges that Defendant Lincare terminated him in violation of 31 U.S.C. § 3730(h).[5] [*See* Compl. at 54]. Count III is an identical retaliation claim against Defendant Rotech. [*See id.* at 55].

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[4] In relevant part, 31 U.S.C. § 3729(a) provides:

Any person who –

(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;

(2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;

(3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid; . . .

is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person. . . .

[5] In relevant part, that section provides:

Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee

(Continued on following page)

Lincare and American HomePatient each filed separate motions to dismiss pursuant to Federal Rules of Civil Procedure 9(b) and 12(b)(6). Additionally, Lincare has filed a motion to file a supplemental brief in light of new authority. Lincare has also filed, and American HomePatient has adopted, the following motions: (1) motion to dismiss qui tam claims on constitutional grounds; (2) motion to dismiss pursuant to 31 U.S.C. § 3730(b) and Federal Rule of Civil Procedure 12(b)(1); and (3) motion to file supplemental brief in light of *United States ex rel. Clausen v. Laboratory Corp. of America, Inc.*, No. 1:97-CV-2200-TWT, 2000 U.S. Dist. LEXIS 17162 (N.D. Ga. Nov. 29, 2000). The government has filed amicus briefs with respect to Defendants' motions to dismiss for failure to comply with Rule 9(b) and 12(b)(6) and on constitutional grounds. Varraux, proceeding *pro se*, has adopted Lincare's renewed motion to dismiss pursuant to Federal Rules of Civil Procedure 9(b) and 12(b)(6) and Lincare's motion to dismiss qui tam claims on constitutional grounds.

Turning first to Defendants' motions to dismiss pursuant to Federal Rules of Civil Procedure 9(b) and 12(b)(6), Defendants maintain that Relator's complaint is deficient in several respects. First, Lincare notes that because Relator refers to Lincare Inc. and Lincare Holdings Inc. collectively as "Lincare," both entities are deprived of proper notice of the allegations levied against

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would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate district court of the United States for the relief provided in this subsection.

them. [*See* Lincare's Renewed Mot. to Dismiss Pursuant to Fed.R.Civ.P. 9(b) and 12(b)(6) at 4]. Second, and most significantly, Lincare argues that Relator's "tainted claim theory" fails to sufficiently plead a violation of 31 U.S.C. § 3729(a)(1). Although Relator alleges generally,

> that 'every' claim for payment is 'false' if submitted after some impropriety has occurred, the [second amended complaint] does not identify one single false claim for payment that [Lincare] allegedly submitted to the government, let alone when, where or who submitted such a claim.

[*Id.* at 5]. Instead, the complaint sets forth, in varying degrees of detail, a wide range of Defendants' allegedly fraudulent or illegal practices. Absent allegations of the submission of specific false claims based upon Defendants' alleged misconduct, Lincare contends that Relator's complaint is fatally flawed.

Furthermore, Lincare maintains that the complaint fails to allege that Lincare submitted a false certification of compliance with federal regulations in violation of 31 U.S.C. § 3729(a)(2). Finally, Lincare submits that the complaint is devoid of any facts supporting Relator's conspiracy claim, such as the existence of an agreement between Defendants and Varraux to engage in fraud or evidence of an overt act taken pursuant thereto. [*Id.* at 8]. Having failed to adequately state a violation of the substantive provisions of the False Claims Act, Lincare avers that Relator's retaliatory discharge claim must fall as well. [*Id.* at 10]; *see* 31 U.S.C. § 3730(h).

In its motion to dismiss Relator's second amended complaint for failure to comply with Federal Rule of Civil Procedure 9(b) and for failure to state a claim, American

HomePatient offers similar arguments as to the deficiency of the complaint. Noting that American HomePatient is alleged to have been involved in only two of the numerous "schemes" outlined in the complaint, American HomePatient contends that Relator's allegations lack the factual specificity demanded by Rule 9(b). For example, Relator alleges that American HomePatient provided free medical equipment in exchange for physician referrals nationwide and throughout "the entire statutory time period." [American HomePatient's Mot. to Dismiss for Failure to Comply with Fed.R.Civ.P. 9(b) at 6]. Although the complaint does allege that such equipment was provided to Dr. Oscar Roadas in Jacksonville, Florida, American HomePatient maintains that such is insufficient for purposes of Rule 9(b). [*Id.* (citing *Rallis v. Holiday Inns, Inc.*, 622 F.Supp. 63, 65 (N.D. Ill. 1985))].

At the outset, Relator urges this court to modify existing law and hold the heightened pleading requirements of Rule 9(b) to be inapplicable to False Claims Act cases. However, in light of binding precedent from the United States Court of Appeals for the Eleventh Circuit holding that Rule 9(b) governs False Claims Act pleadings, the court declines to do so. 566-67 (11th Cir. 1994). Notably, Relator cites no authority, binding or otherwise, to support his argument. *But see United States ex rel. Russell v. Epic Healthcare Management Group,* 193 F.3d 304, 308 (5th Cir. 1999) (noting that "[a] special relaxing of Rule 9(b) is a qui tam plaintiff's ticket to the discovery process that the statute itself does not contemplate); *United States ex rel. Clausen v. Laboratory Corp. of America, Inc.*, No. 1:97-CV-2200-TWT, 2000 U.S. Dist. LEXIS 17162, at *6 (N.D. Ga. Nov. 29, 2000) (rejecting Plaintiff's argument that Rule 9(b) should not apply to False Claims Act

claims). Therefore, the court will apply the heightened pleading standards of Rule 9(b) to Relator's second amended complaint.

Relator maintains that even under the dictates of Rule 9(b), the second amended complaint passes muster. He contends that the complaint adequately sets out:

> the "who" – each scheme defines what Defendant(s) implemented it, and provides so much as possible the names of employees involved; the "what" – various specific types of misconduct, all of which culminated in false Certificates of Medical Necessity and resulting false claims for payment; the "where" – in most cases, nationwide, but with specific locations identified as to every Defendant with respect to every scheme; the "when" – in general, the entire period covered by the Act, but with specific periods (sometimes down to the date) identified by example; and the "how" – the essence of the schemes themselves.

[Relator's Mem. in Opp'n to the Mots. to Dismiss of Defendants Lincare, American HomePatient, and Alan Varraux at 11]. Essentially, Relator appears to argue that by providing sufficient detail regarding the methods by which Defendants allegedly submitted false claims for payment, he has met the requirements of Rule 9(b) for properly pleading a violation of the False Claims Act.

While the Federal Rules of Civil Procedure generally require in a complaint only a short and plain statement of the cause of action, Rule 9(b) states that "[i]n all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity. Malice, intent, knowledge, and other condition of a mind of a person may be averred generally." Fed.R.Civ.P. 9(b). In

addition to providing adequate notice to enable defendants to frame a response, this heightened standard serves to protect defendants from frivolous suits, to preclude fraud actions based upon facts obtained through discovery after the complaint is filed, and to prevent the damage to the goodwill and reputation of defendants that may result from even meritless claims. *United States ex rel. Stinson v. Blue Cross Blue Shield of Ga., Inc.*, 755 F.Supp. 1040, 1053 (S.D. Ga. 1990). Rule 9(b) may be satisfied if the complaint sets forth:

> (1) precisely what statements were made in what documents or oral representations or what omissions were made, and
>
> (2) the time and place of each such statement and the person responsible for making (or, in the case of omissions, not making) same, and
>
> (3) the content of such statements and the manner in which they misled the plaintiff, and
>
> (4) what the defendants "obtained as a consequence of the fraud.

Brooks v. Blue Cross and Blue Shield of Florida, Inc., 116 F.3d 1364, 1371 (11th Cir. 1997) (citations omitted). *See also Leonard v. Stuart-James Co.*, 742 F.Supp. 653, 659 (N.D. Ga. 1990) (motion to dismiss granted where complaint failed to allege "specifically when, where, by whom, or specifically what the representation was.").

Under certain circumstances, Rule 9(b) may be satisfied by alternative means. For example, where a complaint alleged generally that defendants engaged in racketeering activity by corresponding by mail, the submission of an affidavit demonstrating the existence of such correspondence was found to be sufficient. *Durham v. Business*

Management Assocs., 847 F.2d 1505, 1512 (11th Cir. 1988); *see also Seville Indus. Machinery Corp. v. Southmost Machinery Corp.*, 742 F.2d 786 (3d Cir. 1984) (complaint, containing general allegations of misrepresentations and accompanied by a list identifying with specificity the subject of the alleged fraud, was found to be sufficient). Alternatively, where the information needed to plead fraud is peculiarly in the possession of the defendant, a complaint may pass Rule 9(b) muster if it so alleges and contains "a statement of facts upon which the allegations are based." *United States ex rel. Stinson*, 755 F.Supp. at 1052.

The application of this standard recently resulted in the dismissal of a complaint containing allegations similar to those at bar. In *United States ex rel. Butler v. Magellan Health Servs., Inc.*, 101 F.Supp.2d 1365 (M.D. Fla. 2000), a former employee of one of the defendants alleged that defendants (1) submitted fraudulent claims to federal government agencies to obtain benefits and accreditation unlawfully; (2) presented false certification to those agencies to enhance benefits and meet state accreditations; and (3) encouraged unnecessary patient admissions by waiving Medicare deductibles and certain co-payments, and then submitting false claims derived from those admissions. *Id.* at 1367. After dismissing the first amended complaint without prejudice for failure to comply with Rule 9(b), the court analyzed the second amended complaint under the standard set forth by the Eleventh Circuit in *Brooks*, 116 F.3d at 1371. Although the plaintiff had included additional specific facts that expanded upon the general allegations in the first amended complaint, the court noted that:

> Plaintiff pleads generally and never references or produces any such documents which would support false claims to the government. Similarly, there are no time or place allegations relating to false claims. Additionally, Plaintiff has plead no facts relating to content of any false claims or the manner in which they were submitted. Finally, Plaintiff fails to plead what the defendants received specifically as a result of the alleged fraud. The most significant omission in the course of Plaintiff's false claim allegation is the absence of any documents or forms which Plaintiff claims contains some fraud.

United States ex rel. Butler, 101 F.Supp.2d at 1369. Because simply pleading the existence of a fraudulent scheme prohibited by law is insufficient for purposes of the False Claims Act, the court granted the motion to dismiss without leave to amend. *Id.* at 1370.

Applying this standard for pleading fraud with particularity, this court finds that Relator's second amended complaint falls short of compliance with the requirements of Rule 9(b), In his second amended complaint, Relator makes sweeping allegations with little factual specificity. Although some paragraphs of the complaint contain glimpses of the detail demanded by Rule 9(b), such is not sufficient to save an otherwise fact-starved complaint. The court will not analyze each paragraph of the fifty-six page complaint, but will instead cite representative examples of the complaint's shortcomings.

Relator alleges that Lincare provided free equipment to "referring physicians all across the State of Florida and in all places where Lincare does business . . . during the entire statutory time period." [Compl. at 11, ¶ 31]. Although Relator cites three doctors in West Palm Beach,

Florida who allegedly received such equipment, this single example does not adequately support an allegation otherwise unlimited in time and geography.

Relator's allegations with respect to Varraux are similarly deficient. Relator claims Varraux has had a "kickback relationship" with Lincare "since before 1990" involving the "unbundling" of medicines in exchange for "several thousand dollars per month" and "other kickbacks." [*Id.* at 15, ¶ 41]. Such vague assertions regarding the time period and the nature of the alleged fraud cannot survive the scrutiny of Rule 9(b).

The requisite factual detail is also lacking in the allegations regarding American HomePatient. Relator alleges that American HomePatient "entered into medical director agreements with referring physicians across the United States" consisting of monthly payments based on the number of patient referrals. [Compl. at 16, ¶ 45]. Relator again seeks to support this claim with a reference to two doctors in Jacksonville, Florida who allegedly received "approximately $750 per month for many years" pursuant to this referral scheme. [*Id.* at 17, ¶ 48]. Given the breadth of the allegation, this solitary detail is not adequate.

Most importantly, Relator never sufficiently alleges the submission of a false claim for payment to the government, the sine qua non of a False Claims Act violation. Although Relator asserts that Defendants' actions "resulted in the submission of thousands of false claims for payment to the United States," he fails to supply any further details as to when, where, and by whom any such claim was submitted to the government. [*See* Compl. at 19, ¶ 54]; *see also United States ex rel. Cox v. Iowa Health*

System, 29 F.Supp.2d 1022, 1025 (S.D. Iowa 1998) (dismissing False Claims Act count for failure to specify when and by whom each false claim was submitted for payment). Despite the weight of authority to the contrary, Relator seeks to frame his False Claims Act suit by generally alleging fraudulent practices which, in theory, could lead to the submission of false claims. This manner of pleading is not contemplated by the False Claims Act. *See United States ex rel. Clausen*, 2000 U.S. Dist. LEXIS 17162, at *7-8; *accord U.S. ex rel. Schwartz v. Coastal Healthcare Group, Inc.*, No. 99-3105, 2000 WL 1595976 (10th Cir. 2000) (unpublished table decision) (plaintiff "describes only the generalities of how [the allegedly fraudulent scheme] operated, and nowhere does he identify a physician or a specific occasion when the practice resulted in a kickback or other illegal activity."); *U.S. ex rel. Walsh v. Eastman Kodak Co.*, 98 F.Supp.2d 141, 147-48 (D. Mass. 2000) ("Relator's First Amended Complaint, in essence, sets out a methodology by which the vendors might have produced false invoices, which in turn could have led to false claims. Without citing a single false claim arising from an allegedly false invoice, Relator has not met even a bare-bones Rule 9(b) test."); *Ex rel. G. Michael Gublo, et al v. Novacare, Inc.*, 62 F.Supp.2d 347, 354 (D. Mass. 1999) (dismissing complaint under Rule 9(b) where relator alleged three methods by which the defendant inflated its bills to the government, but failed to cite a single instance of a false claim); *United States ex rel. Sanders v. East Alabama Healthcare Authority*, 953 F.Supp. 1404, 1413 (M.D. Ala. 1996) ("While the plaintiffs' First Amended Complaint alleges that (defendants) acted inappropriately during the CON procurement process, the court finds that the complaint does not tie these acts to the

submission of false claims or another activity prohibited by 31 U.S.C. § 3729(a).").

This court finds that the instant action is on all fours with *United States ex rel. Butler*, 101 F.Supp.2d at 1369. Just as the second amended complaint in *Butler* included "additional specific facts that expand upon the general allegations in the Amended Complaint," so too has Relator attempted to perfect his second amended complaint. *See id.* However, this court is likewise compelled to conclude that although "these allegations are illustrative of the type of fraud [Relator] alleges, none of these facts address any false claim or any document bearing a false claim on the part of Defendants." *See id.*

Relator's reliance on *United States ex rel. Johnson v. Shell Oil Co.*, 183 F.R.D. 204 (E.D. Tex. 1998) is unavailing. There, the plaintiff alleged that the defendants falsified monthly reports regarding oil sales and royalty remittances for land owned by the United States and leased by defendants, thereby underpaying their royalty obligations. *Id.* at 207. The plaintiff "set out in some detail seven schemes or methods defendants used to knowingly enter the false claims and underpay their royalty obligations." *Id.* Defendants argued that Rule 9(b) required the plaintiff to provide the specific dates and invoice numbers for each transaction and "the name of each employee who entered the alleged false information upon the [monthly report] for each lease, for each month for the last decade." *Id.* In denying the defendants' motion to dismiss, the court explained that the "particularities of this case do not compel such specifics since the what, when, and where are so obviously exactly plead." *Id.* Because the information sought by the defendants was solely a matter of internal

corporate affairs, the court held that Rule 9(b) did not command such a degree of detail. *Id.*

By contrast, the sparse details contained in the instant complaint do not adequately specify the what, when, and where of any allegedly fraudulent schemes. Moreover, Relator does not allege that the information lacking here is exclusively held by Defendants so as to trigger a relaxed Rule 9(b) standard. Unlike the complaint in *Johnson,* the instant complaint fails to sufficiently identify the conduct complained of such that Defendants could mount a defense. Permitting such a complaint to suffice would contravene one of the primary purposes of Rule 9(b): to notify defendants of the allegations against which they must defend. *Accord United States ex rel. Clausen,* 2000 U.S. Dist. LEXIS 17162, at *8.

Relator also relies on a selective quote from *Georgia Gulf, Corp. v. Ward,* 701 F.Supp. 1556, 1560 (N.D. Ga. 1987), for his argument that Rule 9(b) does not require the inclusion of the dates and times of fraudulent conduct. [*See* Relator's Mem. in Opp'n to the Mots. To Dismiss of Defendants Lincare, American HomePatient, and Alan Varraux at 8]. However, the complete quote appears to support Defendants' position. In denying a motion to dismiss a RICO complaint for failure to comply with Rule 9(b), Judge O'Kelley explained:

> While Georgia Gulf has not alleged the exact dates when kickbacks were received, the complaint clearly shows who received them (Ward and Watkins), who paid them (Roskind and Holtrachem), and how they were paid (indirectly through Carolina Nitrogen, or directly by Roskind and Holtrachem), and how the mails and wires were used in furtherance of the

> scheme. Failure to state the dates and times of receipt of kickbacks is not fatal to the complaint, as the defendants have been apprised of the nature of the action against them, and are therefore on notice of sufficient allegations upon which to mount a defense.

Id. at 1560. Relator's complaint does not appear to contain the level of specificity described above. The isolated instances in which Relator specifies the date, location, persons involved, or method of fraudulent conduct do not sufficiently advise Defendants of the breadth of the charges against them.

To date, Relator has had three opportunities to perfect his complaint. Additionally, this court has previously advised Relator to comply with the requirements of Rule 9(b). *See United States ex rel. Corsello v. Lincare, Inc.*, No. 1:98-CV-0204-ODE, slip op. at 2 (N.D. Ga. June 18, 1999). Although "a plaintiff must be given at least one chance to amend the complaint before the district court dismisses the action with prejudice," the court need not provide Relator with unlimited opportunities to correct his complaint. *Bank v. Pitt,* 928 F.2d 1108, 1112 (11th Cir. 1991). Therefore, because Relator has failed to plead fraud with particularity as mandated by Federal Rule of Civil Procedure 9(b) and as previously directed by this court, the second amended complaint is dismissed with prejudice.

The court will now address Defendants' remaining motions. With respect to Lincare's motion to file a supplemental brief in light of new authority and motion for leave to file supplemental brief in light of *Clausen* decision, the court concludes that this authority is relevant to the resolution of the motion to dismiss, as discussed above. Thus, the court will exercise its discretion to grant said

motions nunc pro tunc. Lincare's remaining motion to dismiss qui tam claims on constitutional grounds and motion to dismiss pursuant to 31 U.S.C. § 3730(b)(5) and Federal Rule of Civil Procedure 12(b)(1) are dismissed as moot in light of the court's granting of Defendants' motion to dismiss pursuant to Federal Rule of Civil Procedure 9(b).

Accordingly, American Inc.'s motion to dismiss Relator's second amended complaint for failure to comply with Federal Rule of Civil Procedure 9(b) and for failure to state a claim [#115] is hereby GRANTED. Lincare Inc. and Lincare Holdings Inc.'s renewed motion to dismiss pursuant to Federal Rules of Civil Procedure 9(b) and 12(b)(6) [#116] is hereby GRANTED. Additionally, Lincare's motion to file a supplemental brief in light of new authority [#144] and Lincare's motion for leave to file supplemental brief in light of *Clausen* decision [#157] are hereby GRANTED NUNC PRO TUNC. Lincare's motion to dismiss qui tam claims on constitutional grounds [#117] and Lincare's motion to dismiss pursuant to 31 U.S.C. § 3730(b)(5) and Federal Rule of Civil Procedure 12(b)(1) [#152] are hereby DISMISSED AS MOOT.

SO ORDERED, this 9 day of MARCH, 2001.

/s/ Orinda D. Evans
ORINDA D. EVANS
UNITED STATES DISTRICT
JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA ex rel. KIRK S. CORSELLO and KIRK S. CORSELLO, Plaintiffs v. LINCARE, INC., LINCARE HOLDINGS INC., AMERICAN HOMEPATIENT, INC., ROTECH INC., and ALAN VARRAUX, M.D., Defendants	CIVIL ACTION NO. 1:98-CV-0204-ODE

ORDER

(Filed Jun. 2, 2003)

This *qui tam* civil action, filed pursuant to the False Claims Act, 31 U.S.C. § 3729 *et seq.*, is before the Court on Defendant Rotech Inc.'s motion to dismiss Relator Corsello's second amended complaint and Relator Corsello's motion for relief from the Court's order dismissing the second amended complaint with regard to Defendants Lincare, Inc., Lincare Holdings Inc., American HomePatient, Inc. and Alan Varraux and motion to amend the second amended complaint. For the reasons stated below, Defendant's motion to dismiss is GRANTED in part and DENIED in part; Relator's motion for relief from the Court's order dismissing the second amended complaint with regard to Defendants Lincare, Inc., Lincare Holdings Inc., American HomePatient, Inc. and Alan Varraux is GRANTED in part and DENIED in part; and Relator's motion to amend the second amended complaint is DENIED.

I. Background

Relator brought this action on January 22, 1998, under the False Claims Act, 31 U.S.C. § 3729 *et seq.* Relator alleges that Defendants engaged in Medicare fraud against the United States government through various fraudulent schemes designed to obtain Medicare payments unlawfully. Relator further alleges that he was illegally terminated in retaliation for the filing of this suit. The United States has not intervened in this case.

On June 18, 1999, this Court granted Relator's motion to file an amended complaint. Relator served his first amended complaint on July 14, 1999. In an apparent attempt to cure some of the deficiencies in his first amended complaint, Relator then filed a second amended complaint on January 13, 2000, reducing the number of named defendants[1] to include Lincare, Inc., Lincare Holdings Inc., Rotech Medical Corporation, American HomePatient, Inc., and Dr. Alan Varraux.

Lincare Inc. and Lincare Holdings Inc. ["Lincare"],[2] American HomePatient, and Rotech are nationwide providers of durable medical equipment and home health services. Varraux is a physician specializing in pulmonology who allegedly had a medical director agreement with Lincare. Relator states that he was employed by Lincare as a Center Manager for the South Orlando Center from August 15, 1995 through December 19, 1997. Compl. ¶ 5.

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[1] Originally, Relator named fifty-six entities and ninety-nine John Doe(s) and John Doe corporations as defendants.

[2] In his pleadings, Relator refers to Lincare, Inc. and Lincare Holdings, Inc. collectively as "Lincare." Because it is impossible to ascertain to which Lincare entity Relator refers, the Court will likewise refer to both entities collectively.

Additionally, Relator asserts that he was employed by Rotech as a Regional Sales Support person from August, 1998, through November 4, 1999. *Id.* Based upon information allegedly obtained during his employment with Lincare and Rotech, Relator asserts that Defendants engaged in various schemes resulting in violations of the False Claims Act.

In his second amended complaint, Relator asserts three counts of False Claims Act violations based on these allegedly fraudulent schemes. In Count I, Relator alleges that all Defendants violated 31 U.S.C. § 3729(a)(1) and (a)(2)[3] by presenting false claims for payment and by submitting false records or statements for the purpose of payment of false claims. *See* Compl. ¶¶ 189-96. In Count II, Relator alleges that Defendant Lincare terminated him in violation of 31 U.S.C. § 3730(h).[4] *See id.* ¶¶ 197-200.

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[3] In relevant part, 31 U.S.C. § 3729(a) provides:

Any person who –

(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;

(2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;

(3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid; . . .

is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person. . . .

[4] In relevant part, section 3730(h) provides:

Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or

(Continued on following page)

Count III is an identical retaliation claim against Defendant Rotech. *See* Compl. ¶¶ 201-04.

Lincare and American HomePatient each filed separate motions to dismiss pursuant to Federal Rules of Civil Procedure 9(b) and 12(b)(6). Varraux, proceeding *pro se*, adopted Lincare's motion to dismiss pursuant to Federal Rules of Civil Procedure 9(b) and 12(b)(6). In an order dated March 29, 2001, the undersigned granted these motions to dismiss, finding that Relator had failed to plead fraud with particularity as mandated by Federal Rule of Civil Procedure 9(b) and as previously directed by this Court.[5]

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her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate district court of the United States for the relief provided in this subsection.

[5] In the order granting Relator's motion to file an amended complaint, the Court cautioned Relator as follows:

> The *Qui Tam* Act was not enacted in order to give the relator an unlimited opportunity to perfect its complaint or the government an unlimited opportunity to elect to intervene. However, in consideration of judicial economy and in light of the fact that none of the parties to this action have yet been served, the court hereby GRANTS Plaintiff's motion for leave to amend the complaint. Plaintiff shall submit an amended complaint within ten (10) days of the entry of this

(Continued on following page)

II. Defendant Rotech's Motion to Dismiss

Defendant Rotech, having filed a notice of bankruptcy stay on February 25, 2000, did not file a motion to dismiss at that time. According to Rotech, its reorganization plan was confirmed by the Bankruptcy Court for the District of Delaware on February 13, 2002, and the stay has now been terminated. In its currently pending motion to dismiss, Defendant Rotech argues that because the allegations against it are almost identical to the allegations raised against Defendants Lincare and American HomePatient, Inc., the allegations against Defendant Rotech must also be dismissed. While the Federal Rules of Civil Procedure generally require in a complaint only a short and plain statement of the cause of action, Rule 9(b) states that "[i]n all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity. Malice, intent, knowledge, and other condition of a mind of a person may be averred generally." Fed.R.Civ.P. 9(b). In addition to providing adequate notice to enable defendants to frame a response, this heightened standard serves to protect defendants from frivolous suits, to preclude fraud actions based upon facts obtained through discovery after the complaint is filed, and to prevent the damage to the goodwill and reputation of

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order. The amended complaint shall fully comport with the requirement of Fed.R.Civ.P. 9(b), which requires that fraud be plead with specificity. The plaintiff's complaint must allege the details of the defendant's allegedly fraudulent acts, when they occurred, and who engaged in them. *Cooper v. Blue Cross and Blue Shield of Florida*, 19 F.3d 562 568 (11th Cir. 1994). There will be no further extensions of time.

United States ex rel. Corsello v. Lincare, Inc., No. 1:98-CV-0204-ODE, slip op at 2 (N.D. Ga. June 18, 1999).

defendants that may result from even meritless claims. *U.S. ex rel. Stinson, Lyons, Gerlin & Bustamante, P.A. v. Blue Cross Blue Shield of Ga., Inc.*, 755 F.Supp. 1040, 1053 (S.D. Ga. 1990). Rule 9(b) may be satisfied if the complaint sets forth:

> (1) precisely what statements were made in what documents or oral representations or what omissions were made, and
>
> (2) the time and place of each such statement and the person responsible for making (or, in the case of omissions, not making) same, and
>
> (3) the content of such statements and the manner in which they misled the plaintiff, and
>
> (4) what the defendants "obtained as a consequence of the fraud.

Brooks v. Blue Cross and Blue Shield of Fla., Inc., 116 F.3d 1364, 1371 (11th Cir. 1997) (citations omitted); *see also Leonard v. Stuart-James Co., Inc.*, 742 F.Supp. 653, 659 (N.D. Ga. 1990) (granting motion to dismiss where complaint failed to allege "specifically when, where, by whom, or specifically what the representation was").

Applying this standard, this Court finds that Relator's second amended complaint as against Defendant Rotech falls short of compliance with the requirements of Rule 9(b). Relator alleges that Defendant Rotech employed the following methods to defraud the Medicare system: (1) improper testing and qualification of patients for certain services by falsifying diagnoses and/or test results, manipulating tests to achieve a qualifying result, and qualification of patients by Defendants rather than an independent medical practitioner; (2) delivery of excess and unneeded unit dose medications; (3) re-renting

equipment which has already been fully paid for by Medicare (referred to as "capped" equipment); (4) billing Medicare for durable medical equipment (DME) no longer in use by the patient; (5) charging Medicare more than private insurance companies are charged for the same services; (6) "unbundling" prescriptions for respiratory medicines so that Defendants could bill the government for the medicines separately; (7) converting Medicare patients to motorized wheelchairs, regardless of medical necessity, which can be billed at a higher rate; and (8) billing Medicare for nursing home patients in Oklahoma that did not exist. Relator alleges that Defendants engaged in the following schemes to circumvent the statutory safeguards intended to prevent these types of fraudulent claims: (1) kickbacks to physicians to induce referrals and falsification of documentation; (2) waiver of patients' 20% co-payment for oxygen services in the absence of any hardship to avoid patients' objections to overcharges or unnecessary equipment or medicine; (3) falsification, forgery, or illegal completion of certificates of medical necessity ["CMN"] to enable the provision of unnecessary treatment and services; and (4) "trolling" for Medicare patients by reviewing physician files to identify patients who may be eligible for oxygen services.

However, Relator never sufficiently alleges the submission of a false claim for payment to the government, the sine qua non of a False Claims Act violation. Instead, Relator seeks to frame his False Claims Act suit by generally alleging fraudulent practices which, in theory, could lead to the submission of false claims. This manner of pleading is not contemplated by the False Claims Act. *U.S. ex rel. Clausen v. Lab. Corp. of Am., Inc.*, 290 F.3d 1301 (2002) (upholding dismissal of False Claims Act count for

failure to specify when and through which procedure each false claim was submitted for payment).

In *Clausen*, the United States Court of Appeals for the Eleventh Circuit clearly establishes the specificity required of False Claims Act allegations:

> Rule 9(b)[ ] . . . does not permit a False Claim Act plaintiff merely to describe a private scheme in detail but then to allege simply and without any stated reason for his belief that claims requesting illegal payments must have been submitted, were likely submitted or should have been submitted to the Government. . . . [I]f Rule 9(b) is to be adhered to, some indicia of reliability must be given in the complaint to support the allegation of *an actual false claim* for payment being made to the Government.

Id. at 1311. This standard may be satisfied by information such as the amount and actual dates of submitted charges, policies about billing or even second-handed information about billing practices, or copies of bills or payments. *Id.* at 1312. While not all of these details are required, "some of this information for at least some of the claims must be pleaded in order to satisfy Rule 9(b)." *Id.* at 1312 n.21.

The sparse details contained in the instant complaint do not adequately specify the what, when, and where of any claim submission. Instead, Relator alleges generally that Defendant Rotech provided services to Medicare patients and was required to obtain certain documentation – namely, the CMNs – to be reimbursed for such services. Relator goes on to specifically allege facts surrounding the falsification of such documentation. For example, Relator alleges that Rotech made direct cash payments to referring physicians and/or members of their staff in Texas

from December 1996 through January 1999 to induce referrals or the falsification of documentation. Compl. ¶ 25. Although Relator cites four doctors and two Defendant employees who allegedly engaged in the kickback scheme, this example does not adequately support an allegation otherwise unlimited in time and geography that Defendants used the kickback scheme to submit false claims. Nor are Relator's allegations with respect to the provision of free or below market tests and services sufficiently specific. Relator alleges that two Rotech employees indicated that they would offer to provide free services to medical professionals but allow the professionals to bill for the services. *Id.* ¶ 29. However, Relator fails to allege that the free services were actually provided or that the medical professionals submitted fraudulent bills based on these services. Relator further alleges that Defendant entered into medical director agreements with two referring physicians in Texas who allegedly received "a monthly fee" pursuant to this referral scheme. *Id.* ¶ 44. Given the breadth of the allegation, this solitary detail is not adequate.

In any case, even if sufficient facts were alleged to support these claims that such schemes existed, Relator's failure to allege the presentation of a false claim precludes liability under the False Claims Act for such acts. *Clausen*, 290 F.3d at 1313 n.24. Relator alleges that based on his personal experience, Rotech provided equipment and services to patients pursuant to CMNs, *see* Compl. ¶¶ 13, 23, 53, 60-63, 65, and that Rotech was required to obtain CMNs to obtain reimbursement for the the provision of equipment and services to government aid recipients. *Id.* ¶¶ 18-20, 52. However, that Rotech provided services pursuant to CMNs and that CMNs were required for

reimbursement does not, without more, establish that Rotech submitted false claims. "The False Claims Act does not create liability merely for a health care provider's disregard of Government regulations or improper internal policies unless, as a result of such acts, the provider knowingly asks the Government to pay amounts it does not owe." *Clausen*, 290 F.3d at 1311. Relator fails to make the necessary link between the alleged obtaining of false CMNs and the submission of any claims for payment and thus has failed to identify any claims for payment predicated on the allegedly false CMNs. Simply put, Relator never alleges any facts with respect to the actual submission of false claims to the government.

Relator provides details such as patient initials and general dates with respect to allegations that Defendant Rotech re-rented capped equipment, billed Medicare for equipment no longer in use, and converted patients to motorized wheelchairs and alleges that Defendant Rotech billed the government for these services and for non-existent nursing home patients in Oklahoma. Compl. ¶¶ 128, 133, 164, 169. These averments arguably constitute allegations that specific claims were submitted; however, Relator wholly fails to allege any factual basis to support the allegations of the actual submission of claims. Relator, as a Rotech employee, may have acquired knowledge about Rotech's billing practices. However, Relator himself indicates that he was employed in a sales position and provides no factual support for his alleged knowledge of billing practices, much less for the specific claims which he asserts were submitted to the government in the above-cited paragraphs. Indeed, Relator claims that he was a Rotech "insider" but fails to allege a factual basis for his claimed knowledge of Rotech's billing policies, other than

that *Rotech* used CMNs in the provision of services and equipment. Rel.'s Opp'n to Def. Rotech's Mot. Dismiss at 12. Relator has thus failed to provide the "indicia of reliability" required to satisfy Rule 9(b). *Clausen*, 290 F.3d at 1311; *U.S. ex rel. Carroll v. JFK Medical Center*, 2002 WL 31941007 (dismissing insider's False Claim Act suit for lack of specificity where allegations failed to provide facts, such as the costs of allegedly fraudulent procedures, to buttress the claims that defendants actually used fraudulent schemes to submit false claims).

Relator's argument that the information lacking here is exclusively held by Defendants so as to trigger a relaxed Rule 9(b) standard is unavailing. In *Clausen*, the Eleventh Circuit rejected such an argument, finding that the relator was not without avenues for obtaining the information and that in any case the relator was not entitled to such leniency because he had not adequately alleged that the information was inaccessible nor plead any facts to support such allegation. *Id.* at 1314 n.25. Similarly, in this case Relator did not allege in the complaint that information with respect to the actual submission of claims to the government was within the exclusive control of Defendant.

Relator argues in the alternative that his allegation that Rotech created false documents is sufficient to state a claim under § 3729(a)(2) of the False Claims Act even in the absence of presentation of claims to the government. Relator relies on the holding in *BMY Combat Sys. Div. of Harsco Corp. v. U.S.*, 38 Fed. Cl. 109 (Fed. Cl. 1997), in which the United States Court of Federal Claims held that actual delivery of false records is not necessary for a False Claims Act violation for false records to attach. However, that case is easily distinguishable from the instant facts: in *BMY Combat*, although the claimant did not actually

give copies of the fraudulent documents to the government, the claimant induced the government's reliance by explicitly stating that the fraudulent forms existed as supporting documents for a proposition that the claimant knew to be false. *Id.* at 126. In this case, there is no allegation that Rotech ever made a specific, explicit representation to the government with respect to a fraudulent document.

However, Relator also argues that even if the Court finds that he has failed to state a cause of action under Rule 9(b) for violations of 31 U.S.C. §§ 3729(a)(1)-(2), his claim of retaliatory discharge is not subject to Rule 9(b) requirements and thus should not be dismissed. Relator alleges that he was terminated in retaliation for the filing of this suit in violation of 31 U.S.C. § 3730(h), which provides relief for employees who are terminated in retaliation for acts in relation to proceedings covered by the False Claims Act. An employee seeking relief under section 3730(h) must prove that he engaged in protected conduct and that the defendant retaliated against her because of that protected conduct. *Mann v. Olsten Certified Healthcare Corp.*, 49 F.Supp.2d 1307, 1313 (M.D.Ala. 1999).

In this case, Relator has alleged sufficient facts to establish that he was engaged in a protected activity when he was terminated. Specifically, Relator alleges that he brought this action while employed by Rotech and that when Rotech learned of the Relator's involvement, his employment was terminated. Compl. ¶¶ 180-82. These allegations are sufficient to state a claim under section 3730(h). *See Hutchins v. Wilentz, Goldman & Spitzer*, 253 F.3d 176, 186 (3d Cir. 2001) (stating elements of retaliation claim as evidence that (1) the employee took acts in

furtherance of a *qui tam* suit; (2) the employer knew of these acts; and (3) his employer discharged him as a result of these acts); *Zahodnick v. Intel Bus. Machines, Corp.*, 135 F.3d 911, 914 (4th Cir. 1997) (same).[6]

Defendant Rotech argues that Relator cannot state a claim for retaliation in the absence of a viable claim of a substantive False Claims Act violation. However, the Eleventh Circuit has held that a relator need not actually file a complaint to state a claim of retaliation. *Childree v. UAP/GM CHEM, Inc.*, 92 F.3d 1140, 1146 (11th Cir. 1996). It follows that the retaliation protection does not depend on the success of the False Claims Act suit, as an actual suit is not required. Rather, retaliation protection is available not only when a suit is filed but also "where the filing of such an action, by either the employee or the government, was a 'distinct possibility' at the time the assistance was rendered." *Id.* Thus, a relator need not have a viable claim of fraudulent billing to state a cause of action but must only take action in furtherance of that claim and suffer adverse employment action as a consequence. *Cf. U.S. ex rel. Yesudian v. Howard Univ.*, 153 F.3d 731, 739-40 (D.C.Cir. 1998) (holding that the protected conduct element of a retaliation claim does not require the plaintiff to have developed a winning *qui tam* action before he is retaliated against); *U.S. ex rel. Satalich v. City of Los Angeles*, 160 F.Supp.2d 1092, 1108

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[6] Defendant Rotech contends that Relator never properly alleged that this *qui tam* action was the basis for the termination of Relator's employment and thus fails to adequately plead a retaliation claim. However, the Court finds that Relator's statement that Defendant Rotech fired him after discovering that he had filed a sealed *qui tam* action against the company is sufficient to support the claim that the *qui tam* action was the basis for his termination.

(C.D.Cal. 2001) (holding that employee-whistleblower's retaliation claim was not dependent on his ability to succeed on, or even file, a cause of action under section 3729). Accordingly, Relator's retaliation claim may go forward despite the dismissal of the underlying False Claims Act allegations.

Because Relator's general allegations that the falsification of these documents led to the submission of false claims are insufficient to state a False Claims Act violation, Relator's specificity with respect to the falsification of the CMNs notwithstanding, Rotech's motion to dismiss is GRANTED with respect to Count I of the complaint. However, because Relator adequately pleaded a retaliation claim, Rotech's motion to dismiss is DENIED with respect to Count III of the complaint.

III. Relator's Motions for Relief from Judgement and to Amend the Complaint

Relator first seeks relief from the order dismissing the second amended complaint with regard to Defendants Lincare, Inc., Lincare Holdings Inc., American HomePatient, Inc. and Alan Varraux, Relator argues that since this Court issued that order, the Eleventh Circuit has clarified the law with respect to the specificity required of False Claim Act complaints and that the Court should therefore withdraw the order dismissing the other Defendants and allow Relator to amend the complaint a fourth time to satisfy the standard as stated in the *Clausen* opinion.

Because the complaint has not been dismissed with prejudice as to all Defendants, the order dismissing Lincare, American HomePatient, and Varraux is not final and thus may be revised at any time. F.R.C.P. 54(b) (noting

that an order addressing fewer than all parties or claims is "subject to revision at any time"); *Bon Air Hotel, Inc. v. Time. Inc.*, 426 F.2d 858, 862 (5th Cir. 1970);[7] *Brogdon ex rel. Cline v. Nat'l Healthcare Corp.*, 103 F.Supp.2d 1322, 1338 (N.D.Ga. 2000). Reconsideration of an interlocutory decision is available under the standard, "as justice requires." Fed. R. Civ. P. 60 advisory committee's note; *see also Canaday v. Household Servs. Inc.*, 119 F.Supp.2d 1258, 1260 (M.D.Ala. 2000) (holding that the trial court may reconsider or reverse its decision on an interlocutory order for any reason it deems sufficient). The Eleventh Circuit's decision in *Clausen* does not constitute a circumstance mandating the relief Relator seeks with respect to the substantive False Claim Act violations. The decision did not change the law. Although the Eleventh Circuit issued the *Clausen* opinion in May, Relator did not attempt to amend the complaint until November. Further, Relator does not explain why he failed to allege the added detail of the proposed third amended complaint in any of the three previous complaints. Finally, the detail Relator seeks to add would not ameliorate the deficiencies which required the dismissal of second amended complaint. Relator simply fails to allege an adequate factual basis to support his assertions that fraudulent claims were submitted to the government.[8]

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[7] This Court adopted as binding precedent all Fifth Circuit decisions prior to October 1, 1981. *Bonner v. City of Prichard*, 661 F.2d 1206, 1209 (11th Cir. 1981) (en banc).

[8] Relator argues in his motion to amend the complaint that he establishes a satisfactory indicia of reliability in the proposed third amended complaint by alleging that he cannot possibly identify billing detail because Defendant maintained its billing departments in remote locations. The Court does not see how this asserted complete lack of

(Continued on following page)

However, Relator also pleaded a retaliation claim against Defendant Lincare similar to the retaliation claim against Rotech. Compl. ¶¶ 197-200. The order dismissing the second amended complaint against Lincare did not specifically address Relator's retaliation claim. Because the Court finds that Relator sufficiently states a claim for retaliation against both Rotech and Lincare, the Court modifies its previous order pursuant to Rule 54(b) to allow Relator's retaliation claim against Lincare to proceed.

Finally, Relator seeks to amend the second amended complaint, purportedly to add the detail found lacking in that pleading. To date, Relator has had three opportunities to perfect his complaint. Additionally, this Court has previously advised Relator to comply with the requirements of Rule 9(b). *See U.S. ex rel. Corsello v. Lincare, Inc.*, No. 1:98-CV-0204-ODE, slip op. at 2 (N.D. Ga. June 18, 1999). Although "a plaintiff must be given at least one chance to amend the complaint before the district court dismisses the action with prejudice," the Court need not provide Relator with unlimited opportunities to correct his complaint. *Bank v. Pitt*, 928 F.2d 1108, 1112 (11th Cir. 1991).

In determining whether to grant a motion to amend a pleading, the district court may consider such factors as "undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the

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knowledge corroborates his claim. Further, although the allegation that the billing records are within Defendants' exclusive control suggests the application of a more lenient standard under Rule 9(b), Relator simply fails to allege adequate facts with respect to his employment at Rotech to support a relaxed specificity requirement.

opposing party by virtue of allowance of the amendment, [and] futility of amendment." *Foman v. Davis*, 371 U.S. 178, 182 (1962); *Nelson v. Doe*, 156 F.R.D. 583, 583 (N.D.Ga. 1995). As noted above, Relator waited over a year from the time the complaint was dismissed against the other defendants and six months from the issuance of the *Clausen* opinion to attempt to amend the complaint, has failed to adequately explain why he has failed to allege the added detail in any of the three previous complaints, and does not ameliorate with the proposed amendment the deficiencies which required that the second amended complaint be dismissed. Allowing Relator to amend the complaint at this point would certainly be inappropriate, given that Relator has unduly delayed the amendment and that an amendment would cause undue prejudice to the opposing party. *See* Fed. R. Civ. P 15(a). Accordingly, Relator's motion to amend the second amended complaint is denied.

IV. Conclusion

For the reasons stated above, Defendant Rotech's motion to dismiss is GRANTED with respect to Count I and DENIED with respect to Count III; Relator's motion for relief from the Court's order dismissing the second amended complaint with regard to Defendants Lincare, Inc,, Lincare Holdings Inc., American HomePatient, Inc. and Alan Varraux is GRANTED with respect to Count II as against the Lincare Defendants and DENIED as against the remaining Defendants; and Relator's motion to amend the second amended complaint is DENIED.

SO ORDERED, this 30 day of MAY, 2003.

/s/ Orinda D. Evans
ORINDA D. EVANS
UNITED STATES
DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

KIRK S. CORSELLO,

Plaintiffs

v.

LINCARE, INC.; LINCARE HOLDINGS INC.; ROTECH INC.; ROTECH MEDICAL CORP.; AMERICAN HOMEPATIENT, INC.; and ALAN VARRAUX, M.D.,

Defendants

CIVIL ACTION NO. 1:98-CV-204-ODE

ORDER

(Filed Jun. 21, 2005)

This civil action, filed pursuant to the False Claims Act ("FCA"), 31 U.S.C. § 3729 *et seq.*, is before the Court on Plaintiff's Second Motion for Reconsideration [Doc. No. 236] and Defendants Lincare, Inc. and Lincare Holding, Inc.'s Motion for Protective Order [Doc. No. 232]. For the reasons stated below, Plaintiff's motion is DENIED, and Defendant's motion is DISMISSED as MOOT.

I. Background

Plaintiff Kirk Corsello[1] filed this FCA action on January 22, 1998, alleging that over fifty defendants

[1] This claim was originally brought as a *qui tam* action and Corsello was listed as relator. All claims brought on behalf of the United States having been dismissed, however, the Court will refer to Corsello as "Plaintiff" in this action.

engaged in Medicare fraud against the United States. Plaintiff further alleged that he was wrongfully terminated in retaliation for the filing of this suit. The United States declined to intervene, and Plaintiff elected to continue this litigation on his own. Between January 1998 and January of 2000, Plaintiff twice amended his complaint.

In an Order dated March 9, 2001, the Court dismissed with prejudice Plaintiff's Second Amended Complaint. The Court held that Plaintiff's "second amended complaint [fell] short of compliance with the requirements of Rule 9(b)" because it "[did] not adequately specify the what, when, and where of any allegedly fraudulent schemes." Order, March 9, 2001, at 14.

On October 18, 2002, Plaintiff filed his First Motion for Reconsideration. On June 2, 2003, the Court granted in part and denied in part Plaintiff's motion. While the Court reinstated Plaintiff's employment claims against Lincare[2] and Rotech,[3] it reaffirmed its prior dismissal of Plaintiff's substantive FCA claims and denial of Plaintiff's motion to file an amended complaint. The Court denied Plaintiff's motion with respect to Plaintiff's substantive FCA claims on the grounds that: (1) there had been no intervening change in the law to justify reconsideration; (2) Plaintiff

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[2] Plaintiff has never distinguished between Defendants Lincare, Inc. and Lincare Holdings, Inc. For purposes of simplicity, the Court will refer to these Defendants jointly as "Lincare" and refer to the Defendants separately only when distinction is required.

[3] Plaintiff originally named only Rotech, Inc. as a Defendant. On December 23, 2004, Rotech Medical Corporation was added as a Defendant in this action by consent. These two entities will be referred to, collectively, as "Rotech."

waited too long (more than 5 months) after the Eleventh Circuit's decision in *United States ex. rel. Clausen v. Lab Corp. Of Am., Inc.*, 290 F.3d 1301 (11th Cir. 2002) to file his motion; (3) Plaintiff did not explain why he failed to allege the added detail of the proposed third amended complaint in any of the three previous complaints; and (4) Plaintiff's proposed third amended complaint still failed to satisfy Rule 9(b). Order, June 2, 2003, at 16.

On February 24, 2005, more than 20 months after the Court's June 2, 2003 Order on Plaintiff's First Motion for Reconsideration, Plaintiff filed his Second Motion for Reconsideration, asking this Court to re-examine its decision that he has not met the requirements of Rule 9(b) with respect to Plaintiff's substantive FCA claims.

On March 4, 2005, eight days after Plaintiff filed his Second Motion for Reconsideration, the parties voluntarily filed a Stipulation of Dismissal with Prejudice, which dismissed Plaintiff's employment claims against all Defendants with prejudice. On April 1, 2005, Plaintiff filed a Notice of Appeal, appealing to the Eleventh Circuit the March 9, 2001 and June 2, 2003 Orders of dismissal, "which were made final judgments by the Stipulation of Dismissal of the remaining claims." Plaintiff's case is currently before the Eleventh Circuit as case number 05-11868-A.

II. Discussion

A. Plaintiff's Second Motion for Reconsideration.

The general rule is that the filing of a notice of appeal, which Plaintiff did in this case on April 1, 2005, "normally divests the district court of jurisdiction over matter concerned in the appeal and transfers jurisdiction over those

matters to the court of appeals." *United States v. Rogers,* 788 F.2d 1472, 1475 (11th Cir. 1986). "The filing of a notice of appeal is an event of jurisdictional significance – it confers jurisdiction on the court of appeals and divests the district court of its control over those aspects of the case involved in the appeal. *Griggs v. Provident Consumer Discount Co.,* 459 U.S. 56, 58 (1982).

One policy reason for recognizing these exceptions is to prevent the use of appeal as a dilatory tactic. *Rogers,* 788 F.2d at 1475. Another is to minimize the possibility that two courts will render conflicting decisions simultaneously. The rule also serves to conserve judicial resources: if both courts' rulings are identical, then efforts have been needlessly duplicated, and if the rulings are dissimilar, the district court has wasted its time and effort.

The Eleventh Circuit, however, has identified several exceptions to this general rule. In all events, the district court will retain the authority to "act in the aid of the appeal, to correct clerical mistakes, or to aid in the execution of a judgment that has not been superceded." *Showtime v. Covered Bridge Condominium Ass'n,* 895 F.2d 711, 713 (11th Cir. 1990). More specific exceptions preserve district court jurisdiction over matters involved in the appeal where the appeal is from the denial of a defendant's frivolous double jeopardy motion, *see Rogers,* 788 F.2d at 1475; where the appeal is from a nonappealable order, *see United States v. Hitchmon,* 602 F.2d 689, 691 (5th Cir. 1979) (en banc); or where the appeal is by the government from a pretrial suppression order, and the district court retains jurisdiction for the purpose of dismissing the indictment, *see United States v. Gatto,* 763 F.2d 1040, 1049 (9th Cir. 1985). Finally, a corollary to the general rule is that the district court will retain jurisdiction over matters

not involved in the appeal, *Diamond Waste, Inc. v. Monroe County, Georgia, et al.*, 869 F. Supp. 944 (M.D. Ga. 1994).

The Eleventh Circuit has held that district courts retain jurisdiction after the filing of a notice of appeal to entertain and deny a motion for reconsideration. *Mahone v. Ray,* 326 F.3d 1176, 1180 (11th Cir. 2003). As explained in *Parks v. U.S. Life and Credit Corp.,* the Eleventh Circuit, along with other circuits and the commentators, has expressly recognized "power in the district court to consider on the merits," and deny a motion for reconsideration after a notice of appeal has been filed, "because the court's action is in furtherance of the appeal." *Parks,* 677 F.2d 838, 840 (11th Cir. 1982).

However, following the filing of a notice of appeal, district courts do not possess jurisdiction to *grant* a motion for reconsideration. Accordingly, a district court presented with a motion for reconsideration after a notice of appeal has been filed "should consider the motion and assess its merits." *Mahone,* 326 F.3d at 1180. The district court "may then deny the motion or indicate its belief that the arguments raised are meritorious." *Id.*. If the district court chooses the latter course, "the movant may then petition the court of appeals to remand the matter so as to confer jurisdiction on the district court to grant the motion." *Id.*.

This Court, therefore, will consider Plaintiff's motion for reconsideration in furtherance of the appeal. First, the Court notes that Plaintiff's Second Motion for Reconsideration is his third attempt to litigate the issue of whether the claims in his Second Amended Complaint are adequately pleaded and his second attempt to have the Court reconsider its dismissal of that complaint for failure to satisfy Fed. R. Civ. P. 9(b). Such serial motions

for reconsideration are clearly prohibited by the Northern District of Georgia's Local Rules, Local Rule 7.2(E) reads as follows:

> **Motions for Reconsideration**. Motions for Reconsideration shall not be filed as a matter of routine practice. Whenever a party or attorney for a party believes it is absolutely necessary to file a motion to reconsider an order or judgment, the motion shall be filed with the clerk of court within ten (1) days after entry of order or judgment. Responses shall be filed not later than ten (1) days after service of the motion. *Parties and attorneys for the parties shall not file motions to reconsider the court's denial of a prior motion for reconsideration.*

(Emphasis added). In addition, Plaintiff's Second Motion for Reconsideration is indefensibly late. Plaintiff filed this motion on February 24, 2005, almost four years after the March 9, 2001 Order dismissing Plaintiff's Second Amended Complaint and over 20 months after the Court's June 2, 2003 partial denial of Plaintiff's First Motion for Reconsideration. Furthermore, Plaintiff never moved for an extension of time to file his motion, exhibited a good faith attempt to comply with the 10-day limit, or demonstrated good cause for his delay.

Second, in addition to Plaintiff's blatant disregard of this Court's local rules, having read and considered Plaintiff's Second Motion for Reconsideration, this Court finds the motion to be entirely without merit. Plaintiff relies on an unpublished Eleventh Circuit opinion, *Hill v. Morehouse Medical Associates,* No. 02-14429, 2003 WL 22019936 (11th Cir. 2003) (per curiam), in support of his position that this Court's application of *Clausen* was in error. In a footnote to

the *Hill* opinion, the Eleventh Circuit clarified the pleading requirements as stated in *Clausen*:

> Failure to allege patient names and the exact dates that claims were submitted to the government, however, is not fatal to a claim under the FCA. Our precedent requires only that "a plaintiff . . . plead . . . the details of the defendants' allegedly fraudulent acts, when they occurred, and who engaged in them." [*Clausen*], 290 F.3d at 1310 (internal quotation marks omitted). . . . Additionally, to require Hill to provide the exact dates that claims were submitted to the government would require that she violate patient confidentiality by copying private records. As we are not prepared to encourage violations of patient confidentiality, we find that Hill need not provide the exact dates that claims were submitted to the government to satisfy rule 9(b).

Hill, 2003 WL 22019936, at *5 n.8. Finding that the *Hill* plaintiff had satisfied Rule 9(b)'s pleading requirement, the Eleventh Circuit reversed and remanded the district court's dismissal of plaintiff's claim.

Because this Court never read *Clausen* to require Plaintiff to allege patient names and the exact dates that claims were submitted to the government, the Eleventh Circuit's decision in *Hill* does not undermine this Court's prior Orders. Consistent with *Hill's* reading of *Clausen,* this Court only required Plaintiff to "adequately specify the what, when, and where of any allegedly fraudulent scheme." Order, March 9, 2001, at 18. Moreover, the facts in *Hill* are readily distinguishable from this case. In *Hill,* the plaintiff "alleged that she observed . . . billers, coders, and physicians alter various CPT [current procedural terminology] and diagnosis codes . . . and thus submit false

claims for Medicare reimbursements." *Hill,* 2003 WL 22019936, at *4. The *Hill* plaintiff was even able to provide "facts describing defendant's billing process, the specific CPT and diagnosis codes that were altered for each of the five billing schemes, and the frequency of submission of each type of claim. *Id.*. Throughout her complaint, the Hill plaintiff "identified the confidential documents within [defendant's] exclusive possession that contain[ed] additional evidence of the fraud." *Id.*. Unlike the plaintiff in *Hill,* Plaintiff Corsello's Second Amended Complaint made "sweeping allegations with little factual specificity." Order, March 9, 2001, at 14. Corsello "never sufficiently allege[d] the submission of a false claim for payment to the government, the sine quo non of a [FCA] violation." *Id.* at 15. Instead, Plaintiff sought to frame his FCA suit only by "generally alleging fraudulent practices which, in theory, *could* lead to the submission of false claims." *Id.* (emphasis added). In addition, unlike the plaintiff in *Hill,* Plaintiff Corsello never alleged that the information lacking here is exclusively held by Defendants so as to trigger a relaxed Rule 9(b) standard. The Court finds, therefore, that Plaintiff's reliance on *Hill* is unavailing.

To date, Plaintiff has had three opportunities to perfect his complaint. Additionally, this court has previously advised Plaintiff to comply with the requirements of Rule 9(b). *See* Order, June 18, 1999. Although "a plaintiff must be given at least one chance to amend the complaint before the district court dismisses the action with prejudice," the court need not provide Relator with unlimited opportunities to correct his complaint. *Bank v. Pitt,* 928 F.2d 1108, 1112 (11th Cir. 1991). This rule has particular force where Plaintiff does not explain why he failed to

allege the added detail of the proposed third amended complaint in any of the previous complaints.[4]

For the foregoing reasons, Plaintiff's Second Motion for Reconsideration is DENIED.

B. Defendant Lincare's Motion for Protective Order

After dismissing all of Plaintiff's claims other than two employment claims against Lincare and Rotech, on September 9, 2003, the Court ordered Plaintiff to provide a more definite statement of his two remaining employment claims. On September 29, 2004, Lincare filed its initial disclosures, identifying two of Plaintiff's personnel files as holding materials that Lincare may use to support its claims or defenses and stated that "copies of all non-privileged materials in [these] file[s] will be provided to Plaintiff." During production of these personnel files on October 15, 2004, Lincare inadvertently produced a single handwritten document from an attorney-client conversation that took place in December 1997. After learning of the disclosure, Lincare's counsel immediately contacted Plaintiff's attorneys in writing to explain the privileged

[4] The Court has reviewed the factual materials submitted by Plaintiff in support of his motion. With the exception of one unnotarized declaration dated February 14, 2004, all of these materials were apparently available well before the Court's March, 9, 2001 dismissal, *See* witness statements submitted as Exhibits B (dated June 19, 2000), L (dated January 19, 1999), M (dated August 18, 1999), N (dated March 4, 1999), and O (dated March 12, 1999); medical records submitted as Exhibits P (copies dated from April 10, 1998 to March 12, 1999); Q (copies dated from October 21, 1998 to March 9, 1999), R (copies dated from July 13, 1998 to March 9, 2000), S (copies dated from June 2, 1998 to September 24, 1999), and T (copies dated from December 16, 1998 to October 21, 1999).

nature of the disclosure and requested that Plaintiff's counsel return the document and all copies. On December 8, 2004, Plaintiff's counsel refused to return the document, arguing that the production of the subject document waives the privilege with regard to any communication . . . regarding the termination of Kirk Corsello." Defendant Lincare filed a motion for a protective order regarding this document on January 28, 2005. Plaintiff has not filed a response in opposition.

The Court notes that the parties have since voluntarily dismissed the employment claims against Lincare and Rotech. Accordingly, Defendant Lincare's motion for protective order is hereby DISMISSED as MOOT.

III. Conclusion

For the foregoing reasons, Plaintiff's Motion for Reconsideration [Doc. No. 236] is DENIED; Defendants Lincare Inc. and Lincare Holding Inc.'s Motion for Protective Order [Doc. No. 232] is DISMISSED as MOOT.

The Court notes that although the Fifth Amended Complaint names Alan Varraux and American HomePatients, Inc. as Defendants, the body of Fifth Amended Complaint does not identify them as parties and makes no allegations against them. This Court having previously dismissed Plaintiff's substantive FCA claims against Alan Varraux and American HomePatients, Inc., *see* Order, March 9, 2001, and having denied both motions for reconsideration on this claim, there are no other pending claims against Alan Varraux and American HomePatients, Inc., even though the Stipulated Dismissal of Plaintiff's Fifth Amended Complaint included only Defendants Lincare

and Rotech. Accordingly, the Clerk is DIRECTED to enter judgment for all Defendants.

SO ORDERED, this 21 day of June, 2005.

/s/ Orinda D. Evans
ORINDA D. EVANS
UNITED STATES
DISTRICT JUDGE